PROTOCOL CODE: GIFUART

DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA_____m^2

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)
☐ CBC & Diff day of treatment
May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.5 x 10^9/L, platelets greater than or equal to 100 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.
ondansetron 8 mg PO prior to treatment
dexamethasone 8 mg PO prior to treatment
☐ **Other:**

TREATMENT: Begins on **Day 1** of each radiotherapy course

mitomycin 10 mg/m^2 x BSA x (_____%) = _____mg (Maximum dose = 20 mg)
IV push on **Day 1, Week 1 and**
☐ **mitomycin 10 mg/m^2** x BSA x (_____%) = _____mg (Maximum dose = 20 mg)
IV push on **Day 1,Week 5 (optional)**

fluorouracil 1000 mg/m^2/day x BSA = _____mg**/day** for 4 days (total dose = _____ mg over 96 hours)
☐ Dose Modification:_____% =_____ mg/m^2/day x BSA =_____ mg/day for 4 days (total dose =_____mg over 96 h)
IV in D5W to a total volume of 480 mL by continuous infusion at 5 mL/h via TWO Baxter LV5 infusors (Total dose should be divided equally – each 240 mL over 48 hours) **Weeks 1 and 5.**

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and book chemo **Week 5**
☒ **Return in 2 days for second fluorouracil infusor**
☐ Return in _____ weeks for Doctor assessment during RT
☐ Last Cycle. Return in _____ week(s)

CBC & Diff weekly prior to chemotherapy and weekly during radiation therapy
Weekly if clinically indicated:
☐ **total bilirubin** ☐ **ALT**

If clinically indicated:
☐ **CEA** ☐ **CA19-9** ☐ **SCC** ☐ **ECG** ☐ **alkaline phosphatase** ☐ **albumin**
☐ **GGT** ☐ **creatinine** ☐ **sodium** ☐ **potassium**
☐ **INR** weekly ☐ **INR** prior to each cycle
☐ **Other tests:**
☐ **Book for PICC assessment / insertion per Centre process**
☐ **Book for IVAD insertion per Centre process**
☐ **Weekly nursing assessment**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

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