

**PROTOCOL CODE: GIFUPART**

<b>DOCTOR'S ORDERS</b>		Ht _____ cm    Wt _____ kg    BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>		
DATE:	To be given:	Cycle #:
Date of Previous Cycle:		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets, Creatinine day of treatment May proceed with doses as written if within 24 hours <b>ANC greater than or equal to 1.5 x 10<sup>9</sup>/L, Platelets greater than 100 x 10<sup>9</sup>/L, Creatinine Clearance greater than or equal to 60 mL/min.</b> Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ <b>Proceed with treatment based on blood work from _____</b>		
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.		
<b>ondansetron 8 mg PO</b> prior to chemotherapy <b>dexamethasone 8 mg PO</b> prior to chemotherapy <input type="checkbox"/> Other:		
<b>PREHYDRATION:</b> NS 1000 mL IV over 1 hour prior to CISplatin		
<b>CHEMOTHERAPY:</b> Chemotherapy begins on <b>Day 1</b> of each radiotherapy course		
<b>CISplatin 60 mg/m<sup>2</sup> x BSA = _____ mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 500 mL NS with potassium chloride 20 mEq, magnesium sulfate 1 g, mannitol 30 g over 1 hour <b>on Day 1, Weeks 1 and 5.</b>		
<b>fluorouracil 1000 mg/m<sup>2</sup>/day x BSA = _____ mg/day</b> for 4 days (total dose = _____ mg over 96 h) <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> /day x BSA = _____ mg/day for 4 days (total dose = _____ mg over 96h) 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) on <b>Weeks 1 and 5.</b>		
<b>RETURN APPOINTMENT ORDERS</b>		
<input type="checkbox"/> Return in <b>four</b> weeks for Doctor and book chemo <b>Cycle #2, Week 5</b> with RT <input checked="" type="checkbox"/> <b>Return in 2 days for second fluorouracil infusor</b> <input type="checkbox"/> Return in _____ weeks for Doctor assessment during RT <input type="checkbox"/> Last Cycle. Return in _____ week(s)		
<b>CBC &amp; Diff, Platelets</b> weekly prior to radiation therapy <b>CBC &amp; Diff, Platelets, Creatinine, sodium, potassium</b> prior to chemotherapy Weeks 1 and 5. If clinically indicated: <input type="checkbox"/> Bili <input type="checkbox"/> Alk Phos <input type="checkbox"/> GGT <input type="checkbox"/> ALT <input type="checkbox"/> CEA <input type="checkbox"/> SCC <input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle <input type="checkbox"/> <b>Other tests:</b> <input type="checkbox"/> <b>Book for PICC assessment / insertion per Centre process</b> <input type="checkbox"/> <b>Book for IVAD insertion per Centre process</b> <input type="checkbox"/> <b>Weekly Nursing Assessment</b> <input type="checkbox"/> <b>Consults:</b> <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>		
<b>DOCTOR'S SIGNATURE:</b>		<b>SIGNATURE:</b>
		<b>UC:</b>