

PROTOCOL CODE: GIFUPART

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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: _____											
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, creatinine day of treatment May proceed with doses as written if within 24 hours ANC greater than or equal to 1.5 x 10⁹/L, platelets greater than 100 x 10⁹/L, creatinine clearance greater than or equal to 60 mL/minute. Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____											
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. dexamethasone <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) PO 30 to 60 minutes prior to CISplatin <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;">AND select ONE of the following:</td> <td style="width: 5%; text-align: center; padding: 5px;"><input type="checkbox"/></td> <td style="padding: 5px;">aprepitant 125 mg PO 30 to 60 minutes prior to CISplatin and</td> </tr> <tr> <td></td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> <td style="padding: 5px;">ondansetron 8 mg PO 30 to 60 minutes prior to CISplatin</td> </tr> <tr> <td></td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> <td style="padding: 5px;">netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to CISplatin</td> </tr> </table> If additional antiemetic required: <input type="checkbox"/> OLANzapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to CISplatin <input type="checkbox"/> Other: _____			AND select ONE of the following:	<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to CISplatin and		<input type="checkbox"/>	ondansetron 8 mg PO 30 to 60 minutes prior to CISplatin		<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to CISplatin
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PREHYDRATION: NS 1000 mL IV over 1 hour prior to CISplatin											
TREATMENT: Begins on Day 1 of each radiotherapy course CISplatin 60 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 500 mL NS with potassium chloride 20 mEq, magnesium sulfate 1 g, mannitol 30 g over 1 hour on Day 1, Weeks 1 and 5. fluorouracil 1000 mg/m²/day x BSA = _____ mg/day for 4 days (total dose = _____ mg over 96 h) <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² /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 Weeks 1 and 5.											
RETURN APPOINTMENT ORDERS											
<input type="checkbox"/> Return in four weeks for Doctor and book chemo Cycle #2, Week 5 with RT <input checked="" type="checkbox"/> Return in 2 days for second fluorouracil infusor <input type="checkbox"/> Return in _____ weeks for Doctor assessment during RT <input type="checkbox"/> Last Cycle. Return in _____ week(s)											
CBC & Diff, creatinine weekly If clinically indicated: <input type="checkbox"/> total bilirubin weekly <input type="checkbox"/> ALT weekly If clinically indicated: <input type="checkbox"/> CEA <input type="checkbox"/> CA19-9 <input type="checkbox"/> SCC <input type="checkbox"/> ECG <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> GGT <input type="checkbox"/> albumin <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle <input type="checkbox"/> Other tests: <input type="checkbox"/> Book for PICC assessment / insertion per Centre process <input type="checkbox"/> Book for IVAD insertion per Centre process <input type="checkbox"/> Weekly nursing assessment <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.											
DOCTOR'S SIGNATURE:		SIGNATURE: UC:									