Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care.

**PROTOCOL CODE: GIGAJCOX**

### DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>m²</th>
</tr>
</thead>
</table>

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

**DATE:** ____________ To be given: ____________ Cycle(s) #: ____________

Date of Previous Cycle:

- [ ] Delay treatment ______ week(s)
- [ ] CBC & Diff, Platelets day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.2 x 10^9/L, Platelets greater than or equal to 75 x 10^9/L, Creatinine Clearance greater than 50 mL/minute**

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 or 12 mg (circle one) PO prior to treatment
- [ ] Other:

**CHEMOTHERAPY:** All lines to be primed with D5W  
- [ ] Repeat in three weeks

- oxaliplatin 130 mg/m² x BSA = ________ mg  
  - [ ] Dose Modification: ________ mg/m² x BSA = ________ mg  
  - IV in 250 to 500 mL D5W over 2 hours

- capcitabine 1000 mg/m² or ______ x BSA x ( ______ %) = ______ mg PO bid with food x 14 days  
  (Round to nearest 150 mg)

**RETURN APPOINTMENT ORDERS**

- [ ] Return in three weeks for Doctor and Cycle ________
- [ ] Return in six weeks for Doctor and Cycle ____ & _____. Book chemo x 2 cycles
- [ ] Last Cycle. Return in ________ week(s)

CBC & Diff, Platelets, Creatinine, Bili, AST, Alk Phos, Electrolytes, Mg, Ca prior to each cycle

- [ ] INR weekly  
- [ ] INR prior to each cycle  
- [ ] ECG  
- [ ] Other tests:
- [ ] Weekly Nursing Assessment for (specify concern): ______________________  
- [ ] Consults:
- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:** ______________________  
**SIGNATURE:** ______________________  
**UC:** ______________________

BC Cancer Provincial Preprinted Order GIGAJCOX  
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