PROTOCOL CODE: GIGAVTR

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:

TREATMENT: Patients to have received previous cycles of treatment with trastuzumab

trastuzumab 6 mg/kg x _____ kg = _____mg IV in 250 mL NS over 30 minutes every three weeks x_____cycle(s). Observe for 60 minutes post-infusion*

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

acetaminophen 325 to **650 mg** PO PRN for headache and rigors

*Observation period not required after 3 consecutive treatments with no reaction.

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____
☐ Return in _____ weeks for Doctor and Cycle _____
☐ Last Cycle. Return in _____ week(s).

If clinically Indicated:

☐ **CEA** ☐ **CA 19-9** ☐ **ECG** ☐ **MUGA scan** or ☐ **echocardiogram**

☐ **CBC & Diff** ☐ **creatinine** ☐ **sodium** ☐ **potassium**

☐ **total bilirubin** ☐ **ALT** ☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: