BC CANCER
Provincial Health Services Authority

PROTOCOL CODE: GIGECC

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 100 x 10^9/L, and creatinine clearance greater than or equal to 60 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 _____.

dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO 30 to 60 minutes prior to treatment
and **select** ONE of the following:

☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment

☐ Other:

PRE-HYDRATION: 1000 mL NS over 1 hour pre-CISplatin

TREATMENT:

epirubicin 50 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV push

CISplatin 60 mg/m^2 x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 500 mL NS with 20 mEq potassium chloride, 1 g magnesium sulfate, 30 g mannitol over 1 hour

capecitabine 625 mg/m^2 x BSA x (_____%) = _____mg PO BID x 21 days
(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

RETURN APPOINTMENT ORDERS

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

CBC & Diff, creatinine, total bilirubin, ALT prior to each cycle

If clinically indicated:
☐ **CEA** ☐ **CA19-9** ☐ **ECG** ☐ **MUGA scan** or ☐ **echocardiogram**
☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium**
☐ **INR** weekly ☐ **INR** prior to each cycle
☐ **Other tests:**
☐ **Weekly nursing assessment**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: