

PROTOCOL CODE: GIIRINALT

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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/Week #: _____
Date of Previous Cycle: _____		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment May proceed with doses as written if within 24 hours ANC greater than or equal to $1.5 \times 10^9/L$, platelets greater than or equal to $75 \times 10^9/L$ 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 _____. ondansetron 8 mg PO prior to treatment dexamethasone <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) prior to treatment <input type="checkbox"/> Prophylactic atropine 0.3 mg subcutaneously 30 minutes prior to irinotecan <input type="checkbox"/> Other: _____		
TREATMENT: irinotecan $125 \text{ mg/m}^2 \times \text{BSA} =$ _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg IV in 500 mL D5W over 1 hour 30 minutes on Days 1, 8, 15, and 22.		
Counsel patient to obtain supply of loperamide and take 4 mg PO at first onset of diarrhea and then 2 mg PO q 2 h until diarrhea free x 12 hours (may take 4 mg PO q 4 h during the night).		
atropine 0.3 mg subcutaneously prn. May repeat every 30 min to a maximum dose of 1.2 mg for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis or flushing.		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in 6 weeks for Doctor and Cycle _____. Book treatment weekly x 4 <input type="checkbox"/> Last Cycle. Return in _____ weeks.		
CBC & Diff, creatinine, total bilirubin, ALT prior to each treatment If clinically indicated: <input type="checkbox"/> CEA <input type="checkbox"/> CA 19-9 <input type="checkbox"/> ECG <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> albumin <input type="checkbox"/> GGT <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: