PROTOCOL CODE: GIIR

DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m²**

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 96 hours **ANC greater than or equal to 1.5 x 10^9/L, platelets greater than or equal to 100 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Age/ECOG** ☐ **Other Toxicity** _____
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.
ondansetron 8 mg PO 30 minutes prior to treatment
dexamethasone ☐ **8 mg** or ☐ **12 mg** *(select one)* 30 minutes prior to treatment
☐ Prophylactic **atropine 0.3 mg** subcutaneously 30 minutes prior to irinotecan
☐ **Other:**

TREATMENT:

irinotecan 350 mg/m² x BSA = _____mg
☐ Dose Modification: _____mg/m² x BSA = _____mg
IV in 500 mL D5W over 1 hour 30 minutes

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

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

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

If clinically indicated:
☐ **CEA** ☐ **CA 19-9** ☐ **ECG**
☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: