



Provincial Health Services Authority

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: GIIR

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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 #: _____
Date of Previous Cycle: _____		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets day of treatment May proceed with doses as written if within 96 hours ANC greater than or equal to $1.5 \times 10^9/L$, Platelets greater than or equal to $100 \times 10^9/L$ Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Age/ECOG <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 30 minutes prior to treatment dexamethasone <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) 30 minutes prior to treatment <input type="checkbox"/> Prophylactic atropine 0.3 mg subcutaneous <input type="checkbox"/> Other: _____		
CHEMOTHERAPY: irinotecan $350 \text{ mg/m}^2 \times \text{BSA} =$ _____ mg (Maximum dose = 700 mg) <input type="checkbox"/> Dose Modification: _____ mg/m ² \times BSA = _____ mg (Maximum dose = 700 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 to 0.6 mg subcutaneous prn repeat up to 1.2 mg for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis or flushing.		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s)		
CBC & Diff, Platelets prior to each cycle If clinically indicated: <input type="checkbox"/> CEA <input type="checkbox"/> CA 19-9 <input type="checkbox"/> Bilirubin <input type="checkbox"/> ALT <input type="checkbox"/> Alk Phos <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE:
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