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: GIPAVCAP**

For other indications or for more than 6 cycles, a BC Cancer “Compassionate Access Program” request form must be completed and approved prior to treatment.

### DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
</thead>
</table>

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

**DATE:**

To be given: Cycle(s) #:

Date of Previous Cycle:

- [ ] Delay treatment _____ week(s)
- [ ] CBC & diff, platelets day of treatment

May proceed with doses as written if within 96 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than 50 mL/minute

Dose modification for:
- [ ] Hematology
- [ ] Age/ECOG
- [ ] Other Toxicity ____________________

Proceed with treatment based on blood work from __________________________

**CHEMOTHERAPY:**
- [ ] Repeat in three weeks

capecitabine 1250 or 1000 mg/m² (circle one) x BSA x ( _____ %) = _________mg PO bid with food x 14 days

(Round dose to nearest 150 mg)

**RETURN APPOINTMENT ORDERS**

- [ ] Return in three weeks for Doctor and Cycle _________
- [ ] Return in six weeks for Doctor and Cycle _____ & _______
- [ ] Last Cycle. Return in _________ week(s)

CBC & diff, platelets, creatinine prior to each cycle

If clinically indicated:
- [ ] BUN
- [ ] Total Protein
- [ ] Albumin
- [ ] Bilirubin
- [ ] Alk Phos
- [ ] GGT
- [ ] ALT

- [ ] INR weekly
- [ ] INR prior to each cycle

- [ ] Other tests:

- [ ] Weekly Nursing Assessment for (specify concern): ________________

- [ ] Consults:

- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**