PROTOCOL CODE: GIRAJCOX

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(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 1.2 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than 50 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

ondansetron 8 mg PO prior to treatment

Dexamethasone 8 mg or 12 mg (circle one) PO prior to treatment

☐ Other: ________________________________

CHEMOTHERAPY: All lines to be primed with D5W

☐ Repeat in three weeks

oxaliplatin 130 mg/m² x BSA = ________ mg

☐ Dose Modification: __________ mg/m² x BSA = __________ mg
   IV in 250 to 500 mL D5W over 2 hours

☐ RN to administer 250 to 1000 mL D5W concurrently with oxaliplatin infusion, titrated to reduce phlebitis discomfort for patient

capcitabine 1000 mg/m² or ________ x BSA x (_______ %) = ________ mg PO bid with food x 14 days
   (Round to nearest 150 mg)

RETURN APPOINTMENT ORDERS

☐ Return in three weeks for Doctor and Cycle ______

☐ Return in six weeks for Doctor and Cycle _____ & ______. Book chemo x 2 cycles.

☐ Last Cycle. Return in ______ week(s)

CBC & Diff, Platelets, Creatinine, Bilirubin, ALT, Alk Phos, Sodium, Potassium, Magnesium, Calcium prior to each cycle

☐ INR weekly    ☐ INR prior to each cycle

☐ ECG

☐ Other tests: ________________________________

☐ Weekly Nursing Assessment for (specify concern): ________________________________

☐ Consults: ________________________________

☐ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE: ________________________________

SIGNATURE: ________________________________

UC: ________________________________