PROTOCOL CODE: GIRALT

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:

☐ 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, creatinine clearance greater than 65 mL/min.**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity:** _____

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

☐ **prochlorperazine 10 mg** PO or ☐ **metoclopramide 10 to 20 mg** PO prior to treatment

☐ **Other:**

TREATMENT:

☐ **Repeat in three weeks** ☐ **Repeat in four weeks**

raltitrexed 3 mg/m^2 x BSA = _____mg

☐ Dose Modification: _____mg/m^2 x BSA = _____mg

IV in 100 mL NS over 15 minutes

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____

☐ Return in **four** weeks for Doctor and Cycle _____

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

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

☐ Last cycle. Return in _____ week(s)

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

If clinically indicated:

☐ **CEA** ☐ **CA19-9** ☐ **ECG**

☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: