PROTOCOL CODE: GIRCRT

☐ **Option 1 – Cycle 1 During RT and Cycles 2-7 following RT**
☐ **Option 2 – Cycle 1 Prior to RT, Cycle 2 during RT and Cycles 3-7 following RT**
☐ **Option 3 – Cycles 1 & 2 Prior to RT, Cycle 3 during RT and Cycles 4-7 following RT**

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, creatinine** 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 75 x 10^9/L, and creatinine clearance greater than or equal to 50 mL/minute**

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

Proceed with treatment based on blood work from _____

☐ **Pre-operative** *or* ☐ **Post-operative** *(select one)*

TREATMENT - CONCURRENT TREATMENT: *(select one)*

☐ **Option 1: Cycle 1** ☐ **Option 2: Cycle 2** ☐ **Option 3: Cycle 3**

capecitabine 825 mg/m^2 or _____ x BSA x (_____%) = _____ mg PO BID (refer to Capecitabine Suggested Tablet Combination Table for dose rounding). The second dose should be taken 10-12 hours after the first dose. To be dispensed in appropriate weekly intervals Monday to Friday, with Saturday, Sunday and statutory holidays off, beginning on the first day of Radiation Therapy and **ending on the last day of RT**.

TREATMENT: *(select one)*

☐ **Option 1: Cycles 2, 3, 4, 5, 6, 7** ☐ **Option 2: Cycles 1, 3, 4, 5, 6, 7** ☐ **Option 3: Cycles 1, 2, 4, 5, 6, 7**

capecitabine 1250 mg/m^2 or _____ x BSA x (_____%) = _____ mg PO BID x 14 days
(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

DOCTOR'S SIGNATURE:

PROTOCOL CODE: GIRCRT

DATE:

RETURN APPOINTMENT ORDERS

OPTION 1:

☐ Return in _____ weeks for Doctor assessment during RT
☐ Return in _____ weeks after surgery for Doctor and Cycle **2** oral chemo.
Surgery Date if known _____
☐ Return in **three** weeks for Doctor and Cycle ☐ **3**, ☐ **4**, ☐ **5,** ☐ **6 or** ☐ **7** *(select one)* oral chemo
☐ Last Cycle. Return in _____ week(s)

OPTION 2:

☐ Return in **three** weeks for Doctor & oral chemo Cycle **2** (pre-op)
☐ Return in _____ weeks for Doctor assessment during RT
☐ Return in _____ weeks after surgery for Doctor and Cycle **3** oral chemo
Surgery Date if known _____
☐ Return in **three** weeks for Doctor and Cycle ☐ **4**, ☐ **5,** ☐ **6 or** ☐ **7** *(select one)* oral chemo
☐ Last Cycle. Return in _____ week(s)

OPTION 3:

☐ Return in **three** weeks for Doctor & oral chemo Cycle ☐ **2 or** ☐ **3** *(select one)* (pre-op)
☐ Return in _____ weeks for Doctor assessment during RT
☐ Return in _____ weeks after surgery for Doctor and Cycle **4** oral chemo
Surgery Date if known _____
☐ Return in **three** weeks for Doctor and Cycle ☐ **5,** ☐ **6 or** ☐ **7** *(select one)* oral chemo
☐ Last Cycle. Return in _____ week(s)

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

CBC & Diff, creatinine weekly during radiation therapy

If clinically indicated during radiation therapy:
☐ **total bilirubin** weekly ☐ **ALT** weekly

If clinically indicated prior to return appointment:
☐ **CEA** ☐ **CA19-9** ☐ **ECG**
☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium**
☐ **INR** weekly ☐ **INR** prior to each cycle
☐ Other tests:
☐ Weekly nursing assessment for (specify reason): _____
☐ Radiation consult before Cycle _____or in _____ weeks
☐ See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: