**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

<table>
<thead>
<tr>
<th></th>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
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**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

**DATE:**

- Delay treatment ______ week(s)
- CBC & diff, platelets, creatinine 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, and Creatinine Clearance greater than or equal to 50 mL/minute**

**DOCTOR’S SIGNATURE:**

**BC Cancer Provincial Preprinted Order GIRCRT**

Created: December 17, 2007  Revised: 1 Nov 2020
### 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, platelets, creatinine prior to each cycle
- CBC & diff, platelets, creatinine weekly during radiation therapy
- □ 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:**