PROTOCOL CODE: GIRINFRT

☐ **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**_____**m²**

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 72 hours **ANC greater than or equal to 1.5 x 10^9/L and platelets greater than or equal to 50 x 10^9/L (for fluorouracil)**
May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 x 10^9/L and platelets greater than or equal to 75 x 10^9/L, and creatinine clearance greater than or equal to 50 mL/minute (for capecitabine)**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity:** _____
Proceed with treatment based on blood work from _____

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

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

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/m² or** ☐ **_____ mg/m²** (select one) x BSA x (_____%) = _____ mg PO BID x 14 days.
(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

RN to assess for stomatitis and diarrhea prior to **EACH** fluorouracil treatment
Notify Doctor if any signs and symptoms of toxicity prior to administering fluorouracil.

CONCURRENT TREATMENT: *(select one)*

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

fluorouracil 225 mg/m²/day x BSA = _____ mg**/day**
☐ Dose Modification: _____% = _____ mg/m²/day x BSA = _____ mg**/day** continuously
for duration of Radiation Therapy or to a total of 35 calendar days, whichever comes first (dispensed as 7 day infusors) IV beginning on the first day of RT
(Total dose for each 7-day infusor = _____ mg over 168 h), in D5W to a total volume of 252 mL by continuous infusion at 1.5 mL/h via Baxter LV1.5 infusor
Pharmacy: For the final week of RT, dispense _____ day infusor to complete treatment schedule to end of RT (total dose = _____ mg/day x ____ days = _____ mg) (Pharmacy to calculate: total volume of _____ mL over _____ h in D5W by continuous infusion at _____ mL/h via _____ infusor.)

DOCTOR'S SIGNATURE:

PROTOCOL CODE: GIRINFRT

DATE:

RETURN APPOINTMENT ORDERS

OPTION 1:

☐ Return in _____ weeks for Doctor assessment during RT. Book weekly chemo x 5 weeks starting _____

☐ 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 & chemo Cycle **2** (pre-op). Book weekly chemo x 5 weeks starting _____

☐ 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 & Cycle **2** oral chemo (pre-op)

☐ Return in **three** weeks for Doctor & chemo Cycle **3** (pre-op). Book weekly chemo x 5 weeks starting _____

☐ 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 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:

☐ Book for PICC assessment / insertion per Centre process

☐ Book for IVAD insertion per Centre process

☐ 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: