



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: GOENDCAD

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:				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets 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 100 x 10⁹/L Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. dexamethasone 8 mg PO BID for 3 days, starting one day prior to each treatment; patient must receive minimum of three doses pre-treatment ondansetron 8 mg PO 30 minutes prior to CARBOplatin Optional: Frozen gloves starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing. <input type="checkbox"/> Other:				
Have Hypersensitivity Reaction Tray and Protocol Available				
CHEMOTHERAPY:				
DOCEtaxel <input type="checkbox"/> 75 mg/m² <i>or</i> <input type="checkbox"/> 60 mg/m² (select one) x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour. (Use non-DEHP tubing)				
CARBOplatin AUC <input type="checkbox"/> 5 <i>or</i> <input type="checkbox"/> 4 (select one) x (GFR + 25) = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 100 to 250mL NS over 30 minutes.				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s).				
CBC & Diff, Platelets, Creatinine prior to next cycle. <i>If this is Cycle 1: CBC & Diff, Platelets on Day 14.</i> <i>In subsequent cycles, if indicated: <input type="checkbox"/> CBC & Diff, Platelets on Day 14.</i> Prior to next cycle, if clinically indicated: <input type="checkbox"/> Bilirubin <input type="checkbox"/> Alk Phos <input type="checkbox"/> GGT <input type="checkbox"/> ALT <input type="checkbox"/> LDH <input type="checkbox"/> Tot Prot <input type="checkbox"/> Albumin <input type="checkbox"/> CA 15-3 <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 19-9 <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC: