**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: GOOVCATR**

### DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>m²</th>
</tr>
</thead>
</table>

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

**DATE:** To be given: Cycle #:

- [ ] Delay treatment ______ week(s)
- [ ] CBC & Diff, Platelets day of treatment

May proceed with doses as written if within 96 hours ANC greater than or equal to $1 \times 10^9/L$, Platelets greater than or equal to $100 \times 10^9/L$.

Dose modification for:  
- [ ] Hematology  
- [ ] Other Toxicity

Proceed with treatment based on blood work from ____________________________.

### PREMEDICATIONS:

Patient to take own supply. RN/Pharmacist to confirm ____________________________.

- **45 minutes prior to PACLitaxel:**
  - dexamethasone 20 mg IV in 50 mL NS over 15 minutes

- **30 minutes prior to PACLitaxel:**
  - diphenhydramINE 50 mg IV and ranitidine 50 mg IV in 50 mL NS over 20 minutes
  - ondansetron 8 mg PO 30 minutes prior to CARBOplatin.

- [ ] Other:

****Have Hypersensitivity Reaction Tray and Protocol Available**

### CHEMOTHERAPY:

- PACLitaxel 175 mg/m² or _________ mg/m² x BSA = _________ mg
  - [ ] Dose Modification: _________% = _________ mg/m² x BSA = _________ mg
  - IV in 250 to 500 mL (non-DEHP bag) NS over 3 hours. (Use non-DEHP tubing with 0.22 micron or smaller in-line filter)

- CARBOplatin AUC 6 or 5 (circle one) x (GFR + 25) = _________ mg
  - [ ] Dose Modification: _________% = _________ mg
  - IV in 250mL NS over 30 minutes.

### DOCTOR’S SIGNATURE:

| SIGNATURE: |
| UC: |
**DATE:**

<table>
<thead>
<tr>
<th>RETURN APPOINTMENT ORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return in ☐ three weeks, or ☐ four weeks for Doctor and Cycle ________</td>
</tr>
<tr>
<td>☐ Last Treatment. Return in _______ week(s).</td>
</tr>
</tbody>
</table>

**CBC & Diff, Platelets, Creatinine** prior to next cycle.

*If this is Cycle 1: CBC & Diff, Platelets on Day 14.*

*If this is Cycle 1 and RTC is in 4 weeks: CBC & Diff, Platelets on Day 21.*

*In subsequent cycles, if indicated: CBC & Diff, Platelets on ☐ Day 14 and/or ☐ Day 21.*

☐ Prior to next cycle, if clinically indicated:

- ☐ Bilirubin  
- ☐ Alk Phos  
- ☐ GGT  
- ☐ ALT  
- ☐ AST  
- ☐ LDH  
- ☐ Tot Prot  
- ☐ Albumin  
- ☐ CA 15-3  
- ☐ CA 125  
- ☐ CA 19-9

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**