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: LYCHLOR

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** day of treatment

May proceed with doses as written if within 48 hours **ANC greater than or equal to 1.2 x 10^9/L and Platelets greater than or equal to 80 x 10^9/L**

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

Proceed with treatment based on blood work from _____

CHEMOTHERAPY: (Choose one ONLY)

☐ **chlorambucil** ☐ **0.4 mg/kg** or ☐ _____ mg/kg (select one) = _____mg PO for one dose on day 1 every 2 weeks for _____ doses.

Do NOT exceed 0.8 mg/kg every 2 weeks. Round dose to the nearest 2 mg.

OR

☐ **chlorambucil** ☐ **0.2 mg/kg once daily** or ☐ _____ mg/kg (select one) once daily **=** _____ mg PO once daily for 21 days starting on _____.

Round dose to the nearest 2 mg.

OR

☐ **chlorambucil** ☐ **0.1 mg/kg once daily** or ☐ _____ mg/kg (select one) once daily = _____ mg PO once daily.

Mitte: _____

Round dose to the nearest 2 mg.

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____ week(s).

CBC & Diff prior to each cycle, or if using continuous daily dosing, prior to each return appointment.

If clinically indicated: ☐ **HBV viral load** ☐ **ALT**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: