



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: CNAJ12TZRT

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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				
For dual modality treatment: May proceed with doses as written if within 48 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L, and if ordered, ALT less than or equal to 2.5 x ULN, Bilirubin less than 25 micromol/L				
For adjuvant treatment: May proceed with doses as written if within 24 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L, ALT less than or equal to 2.5 x ULN, Bilirubin less than 25 micromol/L and Creatinine less than or equal to 2 x ULN, and if Day 22 ANC greater than or equal to 1 x 10⁹/L, Platelets greater than or equal to 50 x 10⁹/L				
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Hepatotoxicity <input type="checkbox"/> Other Toxicity: _____				
Proceed with treatment based on blood work from _____				
CHEMOTHERAPY:				
Concomitant with RT (dual modality)				
temozolomide 75 mg/m² x BSA = _____ mg PO 1 hour prior to RT especially in the first week of treatment, and in AM on days without RT x _____ week(s) starting on _____. (Round dose to nearest 5 mg)				
Adjuvant treatment starting 4 weeks after RT				
temozolomide 150 mg/m² or _____ mg/m² x BSA = _____ mg PO once daily x 5 days starting on _____. (Round dose to nearest 5 mg)				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> For dual modality treatment: Return in _____ week(s) for Doctor and Week _____.				
<input type="checkbox"/> At completion of radiotherapy: Return in four weeks for Doctor and Cycle _____. (Cycle 1 to start four weeks following RT.)				
<input type="checkbox"/> Return in three weeks after start of RT for Doctor				
<input type="checkbox"/> Last Cycle. Return in _____ week(s).				
<input type="checkbox"/> For dual modality treatment: CBC & Diff, Platelets , weekly x _____ week(s) starting on _____; and ALT, Bili before Week 1 and week 4.				
<input type="checkbox"/> For chemotherapy alone: CBC & Diff, Platelets prior to Day 1 and Day 22; and Creatinine, ALT, Bili prior to Day 1				
If clinically indicated: <input type="checkbox"/> Sodium <input type="checkbox"/> Potassium <input type="checkbox"/> Magnesium <input type="checkbox"/> Calcium				
<input type="checkbox"/> Glucose				
<input type="checkbox"/> CT or MRI head (circle one) in _____ weeks				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> Change MRP to _____				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:		SIGNATURE:		
		UC:		