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: CNELTZRT**



## 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** 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 $10^9$/L, platelets greater than or equal to 100 x $10^9$/L, and if ordered, ALT less than or equal to 2.5 x ULN, total 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 $10^9$/L, platelets greater than or equal to 100 x $10^9$/L, ALT less than or equal to 2.5 x ULN, total bilirubin less than 25 micromol/L,** and if **Day 22 ANC greater than or equal to 1.0 x $10^9$/L, platelets greater than or equal to 50 x $10^9$/L**

Dose modification for: ☐ **Hematology** ☐ **Hepatotoxicity** ☐ **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 until the end of RT starting on _____.

(refer to Temozolomide Suggested Capsule Combination Table for dose rounding)

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 _____.

(refer to Temozolomide Suggested Capsule Combination Table for dose rounding)

## RETURN APPOINTMENT ORDERS

☐ For dual modality treatment: Return in _____ week(s) for Doctor and Week _____.

☐ At completion of radiotherapy: Return in **four** weeks for Doctor and Cycle _____.
(Cycle 1 to start four weeks following RT.)

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

☐ For dual modality treatment: **CBC & Diff,** weekly x 4 week(s) starting on Day 8; and **ALT, total bilirubin, random glucose before Week 4 (on Day 22).**

☐ For chemotherapy alone: **CBC & Diff** prior to Day 1 and Day 22; and **ALT, total bilirubin, random glucose** prior to Day 1

If clinically indicated: ☐ **sodium** ☐ **potassium** ☐ **magnesium** ☐ **calcium** ☐ **creatinine**

☐ **CT** or ☐ **MRI head** *(select one)* in _____ weeks

☐ **Other tests:**

☐ **Consults:**

☐ **Change MRP to** _____

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

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**