

PROTOCOL CODE: CNTEM60

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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 May proceed with doses as written on Day 1 if within 24 hours ANC greater than or equal to $1.5 \times 10^9/L$, Platelets greater than or equal to $100 \times 10^9/L$, ALT less than or equal to $2.5 \times ULN$, Bilirubin less than 25 micromol/L and Day 22 ANC greater than or equal to $1 \times 10^9/L$, Platelets greater than or equal to $50 \times 10^9/L$ 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:		
temozolomide <input type="checkbox"/> 150 mg/m ² or <input type="checkbox"/> _____ mg/m ² (select one) x BSA = _____ mg PO daily at bedtime x 5 days (refer to Temozolomide Suggested Capsule Combination Table for dose rounding)		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in four weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s).		
CBC and Diff prior to each cycle and Day 22 ALT, total bilirubin, random glucose prior to each cycle (Day 1 only) If clinically indicated: <input type="checkbox"/> electrolytes <input type="checkbox"/> magnesium <input type="checkbox"/> calcium <input type="checkbox"/> CT or <input type="checkbox"/> MRI head (select one) every 2 cycles <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: