



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/terms-of-use](http://www.bccancer.bc.ca/terms-of-use) and according to acceptable standards of care.

**PROTOCOL CODE: SADTIC**

<b>DOCTOR'S ORDERS</b>			Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form					
<b>DATE:</b>		<b>To be given:</b>		<b>Cycle #:</b>	
Date of Previous Cycle: _____					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff, Platelets</b> day of treatment May proceed with doses as written if within 96 hours <b>ANC greater than or equal to 1.5 x 10<sup>9</sup>/L, Platelets greater than or equal to 100 x 10<sup>9</sup>/L</b>  Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____ <b>Proceed with treatment based on blood work from</b> _____					
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.					
dexamethasone 10 mg PO 30 to 60 minutes prior to treatment and <b>select ONE</b> of the following:					
<input type="checkbox"/> <b>aprepitant 125 mg PO 30 to 60 minutes prior to treatment</b> <input type="checkbox"/> <b>ondansetron 8 mg PO 30 to 60 minutes prior to treatment</b> <input type="checkbox"/> <b>netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to treatment</b> <input type="checkbox"/> Other: _____					
<b>CHEMOTHERAPY:</b>					
dacarbazine 1.2 g/m <sup>2</sup> x BSA = _____ mg					
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg					
IV in 500 to 1000 mL NS over 1 to 2 hours.					
<b>RETURN APPOINTMENT ORDERS</b>					
<input type="checkbox"/> Return in <input type="checkbox"/> <b>three</b> weeks or <input type="checkbox"/> <b>four</b> weeks (select one) for Cycle _____. <input type="checkbox"/> Last Cycle. Return in _____ weeks.					
<b>CBC &amp; Diff, BUN, Platelets, Creatinine, Alk Phos, gamma GT, SGOT, LD</b> prior to each treatment.  <input type="checkbox"/> <b>CXR</b> <input type="checkbox"/> <b>CT Scan:</b> _____  <input type="checkbox"/> <b>Other Tests:</b>  <input type="checkbox"/> <b>Consults:</b>  <input type="checkbox"/> See general orders sheet for additional requests.					
<b>DOCTOR'S SIGNATURE:</b>					<b>SIGNATURE:</b>
					<b>UC:</b>