



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

PROTOCOL CODE: GIAVDOC

<b>DOCTOR'S ORDERS</b>		Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>				
<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, Alk Phos less than 2.5 x ULN and ASTor ALT less than or equal to 1.5 x ULN.</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> _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____				
<b>dexamethasone 8 mg</b> PO BID for 3 days, starting one day prior to treatment; patient must receive 3 doses prior to treatment				
<b>Optional: Frozen gloves</b> starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing.				
<b>**Have Hypersensitivity Reaction Tray and Protocol Available**</b>				
CHEMOTHERAPY:				
<b>DOCEtaxel 75 mg/m<sup>2</sup></b> x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (Use non-DEHP tubing)				
<b>RETURN APPOINTMENT ORDERS</b>				
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____				
<input type="checkbox"/> Last Cycle. RTC in _____ weeks.				
<b>CBC &amp; Diff, Platelets</b> prior to each cycle Prior to <b>Cycle 4: Bilirubin, ALT, GGT, Alk Phos</b> If Clinically Indicated:				
<input type="checkbox"/> <b>Tot. Prot</b> <input type="checkbox"/> <b>Albumin</b> <input type="checkbox"/> <b>Bilirubin</b> <input type="checkbox"/> <b>GGT</b> <input type="checkbox"/> <b>Alk Phos.</b> <input type="checkbox"/> <b>LDH</b> <input type="checkbox"/> <b>ALT</b> <input type="checkbox"/> <b>BUN</b> <input type="checkbox"/> <b>Creatinine</b> <input type="checkbox"/> <b>CEA</b> <input type="checkbox"/> <b>CA 19-9</b>				
<input type="checkbox"/> <b>Other tests:</b> <input type="checkbox"/> <b>Consults:</b> <input type="checkbox"/> <b>See general orders sheet for further orders</b>				
DOCTOR'S SIGNATURE:		SIGNATURE:		
		UC:		