

PROTOCOL CODE: GIFUART

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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 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		
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____		
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. ondansetron 8 mg PO prior to chemotherapy dexamethasone 8 mg PO prior to chemotherapy <input type="checkbox"/> Other: _____		
CHEMOTHERAPY: Chemotherapy begins on Day 1 of each radiotherapy course mitomycin 10 mg/m² x BSA x (_____ %) = _____ mg (Maximum dose = 20 mg) IV push on Day 1, Week 1 and <input type="checkbox"/> mitomycin 10 mg/m² x BSA x (_____ %) = _____ mg (Maximum dose = 20 mg) IV push on Day 1, Week 5 (optional)		
fluorouracil 1000 mg/m²/day x BSA = _____ mg/day for 4 days (total dose = _____ mg over 96 hours) <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² /day x BSA = _____ mg/day for 4 days (total dose = _____ mg over 96 h) IV in D5W to a total volume of 480 mL by continuous infusion at 5 mL/h via TWO Baxter LV5 infusors (Total dose should be divided equally – each 240 mL over 48 hours) Weeks 1 and 5.		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in four weeks for Doctor and book chemo Week 5 <input checked="" type="checkbox"/> Return in 2 days for second fluorouracil infusor <input type="checkbox"/> Return in _____ weeks for Doctor assessment during RT <input type="checkbox"/> Last Cycle. Return in _____ week(s)		
CBC & Diff, Platelets weekly prior to each cycle and during radiation therapy If clinically indicated: <input type="checkbox"/> Bilirubin <input type="checkbox"/> Creatinine <input type="checkbox"/> CEA <input type="checkbox"/> SCC <input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle <input type="checkbox"/> Other tests: <input type="checkbox"/> Book for PICC assessment / insertion per Centre process <input type="checkbox"/> Book for IVAD insertion per Centre process <input type="checkbox"/> Weekly Nursing Assessment <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: