

PROTOCOL CODE: GOENDCAD

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 96 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 _____. dexamethasone 8 mg PO BID for 3 days, starting one day prior to each treatment; patient must receive minimum of three doses pre-treatment ondansetron 8 mg PO 30 minutes prior to CARBOplatin <input type="checkbox"/> aprepitant 125 mg PO 30 to 60 minutes prior to CARBOplatin If additional antiemetic required: <input type="checkbox"/> OLANzapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to CARBOplatin Optional: Frozen gloves starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing. <input type="checkbox"/> Other:				
Have Hypersensitivity Reaction Tray and Protocol Available				
CHEMOTHERAPY: DOCEtaxel <input type="checkbox"/> 75 mg/m² or <input type="checkbox"/> 60 mg/m² (select one) x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour. (Use non-DEHP tubing) CARBOplatin AUC <input type="checkbox"/> 5 or <input type="checkbox"/> 4 (select one) x (GFR + 25) = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 100 to 250mL NS over 30 minutes.				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s).				
CBC & Diff, Platelets, Creatinine prior to next cycle. <i>If this is Cycle 1: CBC & Diff, Platelets</i> on Day 14. <i>In subsequent cycles, if indicated:</i> <input type="checkbox"/> CBC & Diff, Platelets on Day 14. Prior to next cycle, if clinically indicated: <input type="checkbox"/> Bilirubin <input type="checkbox"/> Alk Phos <input type="checkbox"/> GGT <input type="checkbox"/> ALT <input type="checkbox"/> LDH <input type="checkbox"/> Tot Prot <input type="checkbox"/> Albumin <input type="checkbox"/> CA 15-3 <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 19-9 <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC: