PROTOCOL CODE: CNTMZETO

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:

☐ Delay treatment _____ week(s)

☐ **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 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L, ALT less than or equal to 2.5 x ULN, Bilirubin less than 25 micromol/L** and **Creatinine less than or equal to 1.5 x ULN, and Day 22 ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 50 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ Hepatotoxicity ☐ **Other Toxicity:** _____

Proceed with treatment based on blood work from _____

CHEMOTHERAPY:

temozolomide ☐ **150 mg/m^2** or ☐ _____ **mg/m^2** (select one) x BSA = _____mg PO daily at bedtime x 5 days (days 1 to 5) (refer to Temozolomide Suggested Capsule Combination Table for dose rounding)

etoposide ☐ **50 mg/m^2** or ☐ _____ **mg/m^2** (select one) x BSA = _____mg PO daily x 12 days (days 1 to 12) (Round dose to nearest 50 mg)

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____ week(s).

CBC and Diff, Platelets prior to each cycle and Day 22

Creatinine, ALT, Bili prior to each cycle (Day 1 only)

If clinically indicated: ☐ **Electrolytes** ☐ **Magnesium** ☐ **Calcium** ☐ **Glucose**

☐ **CT** or ☐ **MRI head** *(select one)* every 2 cycles

☐ **Other tests:**

☐ **Consults:**

☐ **Change MRP to** _____

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: