



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 and according to acceptable standards of care.

PROTOCOL CODE: SAAJADIC

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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 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 <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) PO 30 to 60 minutes prior to treatment and select ONE of the following:				
<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to treatment ondansetron 8 mg PO 30 to 60 minutes prior to treatment			
<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to treatment			
<input type="checkbox"/> Other: _____				
CHEMOTHERAPY:				
DOXOrubicin <input type="checkbox"/> 60 mg/m ² or <input type="checkbox"/> _____ mg/m ² (select one) x BSA= _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg				
IV push.				
dacarbazine 850 mg/m ² x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg				
IV in 500 to 1000 mL NS over 1 to 2 hours				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in three weeks for Cycle _____.				
<input type="checkbox"/> Last Cycle. Return in _____ weeks.				
CBC & Diff, Platelets, ALT, Alk Phos, Bilirubin, GGT, LDH prior to each treatment.				
<input type="checkbox"/> CXR				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC: