



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: BRAJAC

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 on 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 90 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 AC treatment and select ONE of the following:				
<input type="checkbox"/>	ondansetron 8 mg PO 30 to 60 minutes prior to AC treatment			
<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to AC treatment ondansetron 8 mg PO 30 to 60 minutes prior to AC treatment			
<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to AC treatment			
<input type="checkbox"/> Other:				
TREATMENT:				
DOXOrubicin 60 mg/m² x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg				
IV push				
cyclophosphamide 600 mg/m² x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg				
IV in 100 to 250 mL NS over 20 minutes to 1 hour				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____				
<input type="checkbox"/> Book filgrastim (G-CSF) SC teaching and first dose on Cycle ____ Day ____				
<input type="checkbox"/> Last Cycle. Return in _____ week(s)				
CBC & Diff prior to each cycle.				
If clinically indicated: <input type="checkbox"/> creatinine <input type="checkbox"/> total bilirubin <input type="checkbox"/> ALT <input type="checkbox"/> LDH				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC: