



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: BRAJFEC

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 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"/>	ondansetron 8 mg PO 30 to 60 minutes prior to treatment			
<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"/> hydrocortisone 100 mg IV PRN				
<input type="checkbox"/> Other: _____				
TREATMENT:				
epirubicin 100 mg/m² x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg				
IV push				
fluorouracil 500 mg/m² x BSA x = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg				
IV push				
cyclophosphamide 500 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 _____ weeks.				
CBC & Diff prior to each cycle. If clinically indicated:				
<input type="checkbox"/> total bilirubin <input type="checkbox"/> creatinine <input type="checkbox"/> MUGA Scan <input type="checkbox"/> echocardiogram				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:				SIGNATURES:
				UC: