

PROTOCOL CODE: BRAVCMPO

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 1.5 x 10⁹/L, platelets greater than 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 _____.		
<input type="checkbox"/> Other: _____		
TREATMENT:		
cyclophosphamide 50 mg PO once daily for 28 days.		
methotrexate 2.5 mg PO BID on Days 1 and 2 of each week x 4 weeks.		
<input type="checkbox"/> DOSE REDUCTION:		
methotrexate 2.5 mg PO once daily on <input type="checkbox"/> Days 1 and 2 OR <input type="checkbox"/> Day 1 (select one) of each week x 4 weeks.		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in four weeks for Doctor and Cycle _____		
<input type="checkbox"/> Last Cycle. Return in _____ week(s).		
CBC & Diff, total bilirubin, ALT prior to each cycle		
If clinically indicated: <input type="checkbox"/> creatinine <input type="checkbox"/> alkaline phosphatase		
<input type="checkbox"/> Other tests:		
<input type="checkbox"/> Consults:		
<input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: