



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 and according to acceptable standards of care

PROTOCOL CODE: GOCXLACATW

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 48 hours ANC greater than or equal to 1.0 x 10⁹/L, platelets greater than or equal to 75 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 _____.					
45 minutes prior to PAClitaxel: dexamethasone 10 mg IV in 50 mL NS over 15 minutes					
30 minutes prior to PAClitaxel: diphenhydrAMINE 25 mg IV in 50 mL NS over 15 minutes and famotidine 20 mg IV in 100 mL NS over 15 minutes (Y-site compatible)					
<input type="checkbox"/> No pre-medication to PAClitaxel required (see protocol for guidelines)					
ondansetron 8 mg PO 30 minutes prior to CARBOplatin					
If IV dexamethasone not given for PAClitaxel, give dexamethasone <input type="checkbox"/> 8 or <input type="checkbox"/> 12 mg (select one) PO prior to CARBOplatin					
If additional antiemetic required:					
<input type="checkbox"/> OLANzapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to CARBOplatin					
<input type="checkbox"/> Other: _____					
Have Hypersensitivity Reaction Tray and Protocol Available					
TREATMENT:					
PAClitaxel 80 mg/m² x BSA = _____ mg					
IV in 100 to 500 mL NS (non-DEHP bag) over 60 minutes once weekly x 6 weeks (use non-DEHP tubing with 0.2 micron in-line filter)					
CARBOplatin AUC 2 x (GFR + 25) = _____ mg					
<input type="checkbox"/> Dose modification: _____ % = _____ mg					
IV in 100 to 250 mL NS over 30 minutes once weekly x 6 weeks					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC:



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DATE:	
RETURN APPOINTMENT ORDERS	
Book treatment weekly for six weeks <input type="checkbox"/> Return weekly for five weeks for Doctor and toxicity assessment. OR <input type="checkbox"/> Return in _____ weeks for Doctor and toxicity assessment. OR <input type="checkbox"/> Treatment completed. Return in one week for Doctor and GOCXCRT	
CBC & Diff, creatinine, total bilirubin, ALT weekly prior to treatment If clinically indicated: <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> LDH <input type="checkbox"/> GGT <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> magnesium <input type="checkbox"/> calcium <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 15-3 <input type="checkbox"/> CA 19-9 <input type="checkbox"/> CEA <input type="checkbox"/> SCC <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: