

**PROTOCOL CODE: GOOVCARB**

Page 1 of 1

<b>DOCTOR'S ORDERS</b>		Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>				
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>		
Date of Previous Cycle:				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff</b> day of treatment May proceed with doses as written if within 96 hours <b>ANC greater than or equal to 1.0 x 10<sup>9</sup>/L, platelets greater than or equal to 100 x 10<sup>9</sup>/L</b> Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____ <b>Proceed with treatment based on blood work from</b> _____				
<b>PREMEDICATIONS:</b> 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 CARBOplatin		
	<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to CARBOplatin, and ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin		
	<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to CARBOplatin		
If additional antiemetic required:				
<input type="checkbox"/> <b>OLANzapine</b> <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 treatment				
<input type="checkbox"/> <b>Other:</b>				
<b>**Have Hypersensitivity Reaction Tray and Protocol Available**</b>				
<b>TREATMENT:</b>				
CARBOplatin AUC <input type="checkbox"/> 6 or <input type="checkbox"/> 5 (select one) x (GFR + 25) = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg				
IV in 100 to 250 mL NS over 30 minutes.				
<b>RETURN APPOINTMENT ORDERS</b>				
<input type="checkbox"/> Return in <b>four</b> weeks for Doctor and Cycle _____				
<input type="checkbox"/> Last Cycle. Return in _____ week(s).				
CBC & Diff on <input type="checkbox"/> Day 14 <input type="checkbox"/> Day 21.				
CBC & Diff, <b>creatinine</b> prior to next cycle.				
If this is Cycle 1 and indicated: <input type="checkbox"/> CT Scan chest/abdo/pelvis between Cycles 2 & 3				
<input type="checkbox"/> Referral to Gyne Onc Surgeons after CT Scan				
Prior to next cycle, if clinically indicated:				
<input type="checkbox"/> <b>sodium</b> <input type="checkbox"/> <b>potassium</b> <input type="checkbox"/> <b>magnesium</b> <input type="checkbox"/> <b>calcium</b>				
<input type="checkbox"/> CA 15-3 <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 19-9 <input type="checkbox"/> <b>CEA</b> <input type="checkbox"/> <b>SCC</b>				
<input type="checkbox"/> Refer to Hereditary Cancer Program (see accompanying referral form)				
<input type="checkbox"/> <b>Other tests:</b>				
<input type="checkbox"/> <b>Consults:</b>				
<input type="checkbox"/> See general orders sheet for additional requests.				
<b>DOCTOR'S SIGNATURE:</b>				<b>SIGNATURE:</b>
				<b>UC:</b>