



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: GOOVTOP

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------|-------------|-------------------|--------------------------|
| 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 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 _____ | | | | | |
| dimenhyDRINATE 50 to 100 mg PO prior to topotecan | | | | | |
| CHEMOTHERAPY: | | | | | |
| topotecan <input type="checkbox"/> 1.25 mg/m ² /day or <input type="checkbox"/> 1 mg/m ² /day (select one) x BSA = _____ mg | | | | | |
| <input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg | | | | | |
| IV in 50 mL NS over 30 minutes daily x 5 days. | | | | | |
| RETURN APPOINTMENT ORDERS | | | | | |
| <input type="checkbox"/> Return in three weeks for Doctor and Cycle _____. Book chemo to Days 1 to 5. | | | | | |
| <input type="checkbox"/> Last Cycle. Return in _____ weeks. | | | | | |
| Cycle 1: Prior to Day 1: CBC & Diff, creatinine Prior to Days 8 and 15: CBC & Diff | | | | | |
| Subsequent cycles: CBC & Diff, creatinine prior to day 1 If indicated, also CBC & Diff on <input type="checkbox"/> day 8 and <input type="checkbox"/> day 15 | | | | | |
| Prior to next cycle, if clinically indicated: <input type="checkbox"/> total bilirubin <input type="checkbox"/> ALT <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: | |