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: LYFLU

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:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, platelets** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.2 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L,** and **Creatinine Clearance greater than or equal to 70 mL/min**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

CHEMOTHERAPY:

Standard Dose:

☐ **Oral fludarabine 40 mg/m^2/day** x BSA = _____ mg PO daily for **5 consecutive days**.
Round dose to nearest 10 mg.

OR

Dose Modification Required:

☐ **Oral fludarabine 32 mg/m^2/day** x BSA = _____ mg PO daily for **3 consecutive days**.
Round dose to nearest 10 mg.

OR

Standard Dose:

☐ **IV fludarabine 25 mg/m^2/day** x BSA = _____mg
IV in 100 mL NS over 30 minutes daily for **5 days**.

OR

Dose Modification Required:

☐ **IV fludarabine 20 mg/m^2/day** x BSA = _____mg
IV in 100 mL NS over 30 minutes daily for **3 days**.

RETURN APPOINTMENT ORDERS

For Oral Use:

☐ Return in **four** weeks for Doctor and Cycle _____.

☐ Last Cycle. Return in _____ week(s).

For IV use:

☐ Return in **four** weeks for Doctor and Cycle _____. Book chemo x ☐ **5 days** or ☐ **3 days** (select one). (Match to dose duration above)

☐ Last Cycle. Return in _____ week(s).

CBC & Diff, platelets, creatinine prior to each cycle.

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: