BC CANCER
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: BRAJPN

DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m²**

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

Number of PACLitaxel or DOCEtaxel cycles completed to date: _____

☐ 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 1.5 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L, Bilirubin less than or equal to 1.5 x ULN, AST or ALT less than or equal to 10 x ULN**

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

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

☐ **Other:**

CHEMOTHERAPY:

PACLitaxel NAB (ABRAXANE) 260 mg/m² x BSA = _____mg

☐ Dose Modification: _____mg/m² x BSA = _____mg

IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron filter)

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____weeks.

CBC & Diff, Platelets, bilirubin, ALT, creatinine prior to each cycle (GGT, LDH, alkaline phosphatase required prior to Cycle 1)

If clinically indicated: ☐ **Alk Phos** ☐ **GGT** ☐ **BUN**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: