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: GIRAJCOX

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(s) #:**

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 75 x 10^9/L, Creatinine Clearance greater than 50 mL/minute**

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

Proceed with treatment based on blood work from: _____

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

ondansetron 8 mg PO prior to treatment

dexamethasone 8 mg or **12 mg** *(circle one)* PO prior to treatment

NO ice chips

☐ **Other:** _____

CHEMOTHERAPY: All lines to be primed with D5W ☐ **Repeat in three weeks**

oxaliplatin 130 mg/m^2 x BSA = _____ mg

☐ Dose Modification: _____ mg/m^2 x BSA = _____ mg

IV in 250 to 500 mL D5W over 2 hours

To reduce incidence of vascular pain:

☐ 250 mL total volume of D5W to be administered concurrently with oxaliplatin at a maximum rate of 125 mL/h

☐ 500 mL total volume of D5W to be administered concurrently with oxaliplatin at a maximum rate of 250 mL/h

capecitabine 1000 mg/m^2 or _____ x BSA x (_____ %) = _____ mg PO BID x 14 days

(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

RETURN APPOINTMENT ORDERS

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

☐ Return in **six** weeks for Doctor and Cycle _____ & _____. Book chemo x 2 cycles.

☐ Last Cycle. Return in _____ week(s)

CBC & Diff, Platelets, Creatinine, Bilirubin, ALT, Alk Phos, Sodium, Potassium, Magnesium, Calcium prior to each cycle

☐ **INR** weekly ☐ **INR** prior to each cycle

☐ **ECG**

☐ **Other tests:** _____

☐ **Weekly Nursing Assessment for (specify concern):** _____

☐ **Consults:** _____

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: