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: GIRCRT

☐ **Option 1 – Cycle 1 During RT and Cycles 2-7 following RT**
☐ **Option 2 – Cycle 1 Prior to RT, Cycle 2 during RT and Cycles 3-7 following RT**
☐ **Option 3 – Cycles 1 & 2 Prior to RT, Cycle 3 during RT and Cycles 4-7 following RT**

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:

☐ Delay treatment ______ week(s)
☐ **CBC & diff, platelets, creatinine** 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 75 x 10^9/L, and Creatinine Clearance greater than or equal to 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 ___________________________.

☐ **Pre-operative** *or* ☐ **Post-operative** *(please select one)*

CHEMOTHERAPY - CONCURRENT TREATMENT: *(select one)*

☐ **Option 1: Cycle 1** ☐ **Option 2: Cycle 2** ☐ **Option 3: Cycle 3**

capecitabine 825 mg/m² or ________ x BSA x (________%) = ________ mg PO BID (refer to Capecitabine Suggested Tablet Combination Table for dose rounding). The second dose should be taken 10-12 hours after the first dose. To be dispensed in appropriate weekly intervals Monday to Friday, with Saturday, Sunday and statutory holidays off, beginning on the first day of Radiation Therapy and **ending on the last day of RT**.

CHEMOTHERAPY: *(select one)*

☐ **Option 1: Cycles 2, 3, 4, 5, 6, 7** ☐ **Option 2: Cycles 1, 3, 4, 5, 6, 7** ☐ **Option 3: Cycles 1, 2, 4, 5, 6, 7**

capecitabine 1250 mg/m² or ________ x BSA x (______%) = _______ mg PO BID x 14 days
(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

DOCTOR'S SIGNATURE:

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DATE:	
RETURN APPOINTMENT ORDERS	
OPTION 1: ☐ Return in ________ weeks for Doctor assessment during RT ☐ Return in ________ weeks after surgery for Doctor and Cycle **2** oral chemo. Surgery Date if known _______________ ☐ Return in **three** weeks for Doctor and Cycle ☐ **3**, ☐ **4**, ☐ **5,** ☐ **6 or** ☐ **7** *(select one)* oral chemo ☐ Last Cycle. Return in _________ week(s)	
OPTION 2: ☐ Return in **three** weeks for Doctor & oral chemo Cycle **2** (pre-op) ☐ Return in ________ weeks for Doctor assessment during RT ☐ Return in ________ weeks after surgery for Doctor and Cycle **3** oral chemo Surgery Date if known _______________ ☐ Return in **three** weeks for Doctor and Cycle ☐ **4**, ☐ **5,** ☐ **6 or** ☐ **7** *(select one)* oral chemo ☐ Last Cycle. Return in _________ week(s)	
OPTION 3: ☐ Return in **three** weeks for Doctor & oral chemo Cycle ☐ **2 or** ☐ **3** *(select one)* (pre-op) ☐ Return in ________ weeks for Doctor assessment during RT ☐ Return in ________ weeks after surgery for Doctor and Cycle **4** oral chemo Surgery Date if known _______________ ☐ Return in **three** weeks for Doctor and Cycle ☐ **5,** ☐ **6 or** ☐ **7** *(select one)* oral chemo ☐ Last Cycle. Return in _________ week(s)	
CBC & diff, platelets, creatinine prior to each cycle **CBC & diff, platelets, creatinine** weekly during radiation therapy ☐ **INR** weekly ☐ **INR** prior to each cycle ☐ **Other tests:** ☐ **Weekly Nursing Assessment for (specify reason): ________________** ☐ **Radiation consult before Cycle ________or in __________ weeks** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**