

PROTOCOL CODE: GIRINFRT

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- 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 72 hours **ANC greater than or equal to $1.5 \times 10^9/L$ and Platelets greater than or equal to $50 \times 10^9/L$ (for fluorouracil)**

May proceed with doses as written if within 96 hours **ANC greater than or equal to $1.5 \times 10^9/L$ and Platelets greater than or equal to $75 \times 10^9/L$, and Creatinine Clearance greater than or equal to 50 mL/minute (for capecitabine)**

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: (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 _____ **mg/m²** (select one) x BSA x (_____ %) = _____ mg PO BID x 14 days.
(refer to [Capecitabine Suggested Tablet Combination Table](#) for dose rounding)

RN to assess for stomatitis and diarrhea prior to **EACH** fluorouracil treatment
Notify Doctor if any signs and symptoms of toxicity prior to administering fluorouracil.

CONCURRENT TREATMENT: (select one)

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

fluorouracil **225 mg/m²/day** x BSA = _____ **mg/day**

Dose Modification: _____ % = _____ **mg/m²/day** x BSA = _____ **mg/day** continuously

for duration of Radiation Therapy or to a total of 35 calendar days, whichever comes first (dispensed as 7 day infusors)
IV beginning on the first day of RT

(Total dose for each 7-day infusor = _____ mg over 168 h), in D5W to a total volume of 252 mL by continuous infusion at 1.5 mL/h via Baxter LV1.5 infusor

Pharmacy: For the final week of RT, dispense _____ day infusor to complete treatment schedule to end of RT (total dose = _____ mg/day x _____ days = _____ mg) (Pharmacy to calculate: total volume of _____ mL over _____ h in D5W by continuous infusion at _____ mL/h via _____ infusor.)

DOCTOR'S SIGNATURE:

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DATE: _____	
RETURN APPOINTMENT ORDERS	
<p>OPTION 1:</p> <p><input type="checkbox"/> Return in _____ weeks for Doctor assessment during RT. Book weekly chemo x 5 weeks starting _____</p> <p><input type="checkbox"/> Return in _____ weeks after surgery for Doctor and Cycle 2 oral chemo Surgery Date if known _____</p> <p><input type="checkbox"/> Return in three weeks for Doctor and Cycle <input type="checkbox"/> 3, <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 6 or <input type="checkbox"/> 7 (select one) oral chemo</p> <p><input type="checkbox"/> Last Cycle. Return in _____ week(s)</p>	
<p>OPTION 2:</p> <p><input type="checkbox"/> Return in three weeks for Doctor & chemo Cycle 2 (pre-op). Book weekly chemo x 5 weeks starting _____</p> <p><input type="checkbox"/> Return in _____ weeks for Doctor assessment during RT</p> <p><input type="checkbox"/> Return in _____ weeks after surgery for Doctor and Cycle 3 oral chemo Surgery Date if known _____</p> <p><input type="checkbox"/> Return in three weeks for Doctor and Cycle <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 6 or <input type="checkbox"/> 7 (select one) oral chemo</p> <p><input type="checkbox"/> Last Cycle. Return in _____ week(s)</p>	
<p>OPTION 3:</p> <p><input type="checkbox"/> Return in three weeks for Doctor & Cycle 2 oral chemo (pre-op)</p> <p><input type="checkbox"/> Return in three weeks for Doctor & chemo Cycle 3 (pre-op). Book weekly chemo x 5 weeks starting _____</p> <p><input type="checkbox"/> Return in _____ weeks for Doctor assessment during RT</p> <p><input type="checkbox"/> Return in _____ weeks after surgery for Doctor and Cycle 4 oral chemo Surgery Date if known _____</p> <p><input type="checkbox"/> Return in three weeks for Doctor and Cycle <input type="checkbox"/> 5, <input type="checkbox"/> 6 or <input type="checkbox"/> 7 (select one) oral chemo</p> <p><input type="checkbox"/> Last Cycle. Return in _____ week(s)</p>	
<p>CBC & diff, platelets, creatinine prior to each cycle</p> <p>CBC & diff, platelets weekly during radiation therapy</p> <p><input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle</p> <p><input type="checkbox"/> Other tests:</p> <p><input type="checkbox"/> Book for PICC assessment / insertion per Centre process</p> <p><input type="checkbox"/> Book for IVAD insertion per Centre process</p> <p><input type="checkbox"/> Weekly Nursing Assessment for (specify reason): _____</p> <p><input type="checkbox"/> Radiation consult before Cycle _____ or in _____ weeks</p> <p><input type="checkbox"/> See general orders sheet for additional requests.</p>	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: