



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: HNLACART3

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:		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> Day of treatment: CBC & Diff		
May proceed with doses as written, if within 96 hours ANC <u>greater than or equal to</u> 1.0 x 10⁹/L and Platelets <u>greater than or equal to</u> 100 x 10⁹/L		
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____		
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin dexamethasone 8 mg PO 30 to 60 minutes prior to CARBOplatin <input type="checkbox"/> Other:		
** Have Hypersensitivity Reaction Tray and Protocol Available**		
TREATMENT:		
CARBOplatin AUC 5 x (GFR + 25) = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 100 to 250 mL NS over 30 minutes		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in 3 weeks for Doctor and Cycle _____. <input type="checkbox"/> Last Cycle. Return in _____ week(s).		
CBC & diff, platelets, creatinine, sodium, potassium, magnesium, calcium, and phosphate, albumin prior to each treatment <input type="checkbox"/> If clinically indicated: <input type="checkbox"/> ALT <input type="checkbox"/> bilirubin <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: