



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: LUAVCRIZ

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:				
TREATMENT:				
<input type="checkbox"/> crizotinib 250 mg twice daily. Supply for: _____ days.				
<input type="checkbox"/> crizotinib 200 mg twice daily. Supply for: _____ days (dose level -1)				
<input type="checkbox"/> crizotinib 250 mg once <i>daily</i> . Supply for: _____ days (dose level -2)				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in _____ weeks for Doctor				
CBC, Alk Phos, ALT, Bili, LDH every two weeks during Cycle 1 and Cycle 2 CBC, Alk Phos, ALT, Bili, LDH at each doctor's visit Imaging (approx. every 4-8 weeks): <input type="checkbox"/> Chest X-ray or <input type="checkbox"/> CT Scan (chest) <input type="checkbox"/> ECG (if clinically indicated) <input type="checkbox"/> calcium <input type="checkbox"/> magnesium <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> creatinine <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:			SIGNATURE:	
			UC:	