



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: SAMV

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** day of treatment

May proceed with doses as written if within 36 hours **ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L**

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

Proceed with treatment based on blood work from _____

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

- prochlorperazine** 10 mg PO ½ hour before treatment
- OR**
- dimenhydrinate** 50 mg PO ½ hour before treatment

CHEMOTHERAPY:

Drugs to be given **Weekly x 4** or **every second week x 2 (select one)** (1 cycle = 4 weeks)

methotrexate 30 mg/m² x BSA x _____% = _____ mg IV push

AND

vinBLASTine 6 mg/m² x BSA x _____% = _____ mg IV in 50 mL NS over 15 minutes

RETURN APPOINTMENT ORDERS

- Return in _____ weeks for Cycle _____.
- Last Cycle. Return in _____ weeks.

CBC & Diff, Platelets prior to each treatment.

If Clinically Indicated:

- Other tests:** Chest X-ray
- CT scan _____ in 3 or 4 months (select one)

Consults:

See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: