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: GIPAVCAP

For other indications or for more than 6 cycles, a BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment.

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(s) #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)
☐ CBC & diff, platelets 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, Creatinine Clearance greater than 50 mL/minute**

Dose modification for: ☐ **Hematology** ☐ **Age/ECOG** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

CHEMOTHERAPY: ☐ **Repeat in three weeks**

capecitabine ☐ **1250** or ☐ **1000 mg/m^2** *(select one)* x BSA x (_____%) = _____mg PO BID x 14 days

(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____
☐ Return in **six** weeks for Doctor and Cycle _____ & _____.
☐ Last Cycle. Return in _____ week(s)

CBC & diff, platelets, **creatinine** prior to each cycle

If clinically indicated: ☐ **BUN** ☐ **Total Protein** ☐ **Albumin**
☐ **Bilirubin** ☐ **Alk Phos** ☐ **GGT** ☐ **ALT**

☐ **INR** weekly ☐ **INR** prior to each cycle
☐ **Other tests:**

☐ **Weekly Nursing Assessment for (specify concern):** _____
☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: