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/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: KSVB

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:

☐ Delay treatment ______ week(s)
☐ **CBC & Diff, Platelets** day of treatment
May proceed with doses as written if within 24 hours
☐ **ANC greater than or equal to ____ x 10^9/L, Platelets greater than or equal to ____ x 10^9/L or**
☐ **ANC greater than 1 x 10^9/L, Platelets greater than 74 x 10^9/L (vinBLAStine Only)**
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 or ☐ **metoclopramide 10 mg** PO 30 to 60 minutes prior to treatment
☐ **hydrocortisone 100 mg** IV pre-Bleomycin

CHEMOTHERAPY:

DAY 1:

☐ **vinBLAStine** (circle one) **6 mg, 10 mg, or ________mg**
☐ Dose Modification: (________%) = __________mg
IV in 50 mL NS over 15 minutes

If Neutropenia, omit vinBLAStine
Substitute **bleomycin 10 units/m^2** x BSA =______ units
☐ Dose Modification: (________%) = ____________units/m^2 x BSA = __________units
IV in 50 mL NS over at least 10 minutes

DAY 8:

☐ **vinCRIStine 1 mg**
☐ Dose Modification: (________%) = __________mg
IV in 50 mL NS over 15 mins.

If neurological dysfunction, omit vinCRIStine
Substitute **bleomycin 10 units/m^2** x BSA =______ units
☐ Dose Modification: (________%) = ____________units/m^2 x BSA = __________units
IV in 50 mL NS over at least 10 minutes

OR

methotrexate 25 mg/m^2 x BSA = __________ mg
☐ Dose Modification: ________% = _________ mg/m^2 x BSA = ____________ mg
IV push

RETURN APPOINTMENT ORDERS

☐ Return in ________ weeks for Doctor and Cycle ________ ((Book Chemo Day 1 and 8)
☐ Last Cycle. Return in ________ week(s).

CBC prior to each cycle (if vinBLAStine OR Methotrexate being used)
CR (only required if using Bleomycin and Methotrexate)
If clinically indicated: ☐ **Tot. Prot** ☐ **Albumin** ☐ **Bilirubin** ☐ **GGT** ☐ **Alk Phos.** ☐ **LDH** ☐ **ALT** ☐ **BUN** ☐ **Creatinine**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: