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: LYCYCLO

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 96 hours **ANC greater than 1.2 x 10^9/L, Platelets greater than 80 x 10^9/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 _____.
ondansetron 8 mg PO prior to treatment.
dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO prior to treatment.
☐ **Other:**

CHEMOTHERAPY:

☐ **IV cyclophosphamide** _____ **mg/m^2** = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 100 to 250 mL NS over 20 minutes to 1 hour.

OR

☐ **Oral cyclophosphamide** _____ **mg/m^2/day** = _____mg PO daily x 5 days. (Round dose to nearest 25 mg)

OPTIONAL:
☐ **predniSONE 45 mg/m^2/day** = _____mg PO daily in the AM x 5 days. (Round dose to nearest 25 mg)

RETURN APPOINTMENT ORDERS

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

CBC & Diff, Platelets prior to each cycle

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: