



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](http://www.bccancer.bc.ca) and according to acceptable standards of care

**PROTOCOL CODE: LKAMLCYT**

|   |              |  |
|---|--------------|--|
| <b>DOCTOR'S ORDERS</b>  |              | Ht _____ cm    Wt _____ kg    BSA _____ m <sup>2</sup> |
| <b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>   |              |  |
| DATE:   | To be given: | Cycle #:   |
| Date of Previous Cycle: _____   |              |  |
| <input type="checkbox"/> Delay treatment _____ week(s)<br><input type="checkbox"/> <b>CBC &amp; Diff, Platelets</b> day of treatment<br><b>Cycle 1 ONLY:</b> May proceed with doses as written. No specific blood count requirements<br><b>Cycles 2-4:</b><br>May proceed with doses as written if within 48 hours <b>ANC greater than or equal to 1.5 x 10<sup>9</sup>/L, Platelets greater than or equal to 100 x 10<sup>9</sup>/L</b><br><br>Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____<br>Proceed with treatment based on blood work from _____ |              |  |
| <b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.  |              |  |
| <input type="checkbox"/> <b>Other:</b> _____  |              |  |
| <b>CHEMOTHERAPY:</b>  |              |  |
| cytarabine 20 mg <b>subcutaneous</b> bid for 10 consecutive days starting _____.  |              |  |
| <b>**Prescriptions need to be provided for pharmacy <u>at least 24 hours</u> before patient pick-up**</b>   |              |  |
| <input type="checkbox"/> <b>Special Instructions:</b> _____   |              |  |
| <b>RETURN APPOINTMENT ORDERS</b>  |              |  |
| <input type="checkbox"/> Return in <input type="checkbox"/> four weeks or <input type="checkbox"/> six weeks (select one) for Doctor and Cycle _____.<br><input type="checkbox"/> Last Cycle. Return in _____ week(s).  |              |  |
| <b>CBC &amp; Diff, Platelets prior to each cycle</b><br><br>If clinically indicated: <input type="checkbox"/> <b>Bilirubin</b> <input type="checkbox"/> <b>GGT</b> <input type="checkbox"/> <b>Alk Phos</b> <input type="checkbox"/> <b>LDH</b> <input type="checkbox"/> <b>ALT</b><br><br><input type="checkbox"/> serum creatinine and uric acid<br><br><input type="checkbox"/> <b>Other tests:</b><br><input type="checkbox"/> <b>Consults:</b><br><input type="checkbox"/> See general orders sheet for additional requests.   |              |  |
| <b>DOCTOR'S SIGNATURE:</b>  |              | <b>SIGNATURE:</b>                                      |
| CPSBC ID# _____   |              | <b>UC:</b>   |