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: BRAVCMPO

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 1.5 x 10^9/L, Platelets greater than 100 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 _____.

☐ **Other:**

CHEMOTHERAPY:

cyclophosphamide 50 mg PO once daily for 28 days.

methotrexate 2.5 mg PO BID on Days 1 and 2 of each week x 4 weeks.

☐ **DOSE REDUCTION:**

cyclophosphamide _____ mg PO once daily for 28 days. (Round dose to nearest 25 mg)

methotrexate 2.5 mg PO once daily on ☐ Days 1 and 2 **OR** ☐ Day 1 (select one) of each week x 4 weeks.

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets, **Bilirubin, ALT** prior to each cycle

If clinically indicated: ☐ Creatinine ☐ Alk Phos

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: