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: BRAVDOC

## 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 or equal to 1.5 x $10^9$/L, Platelets greater than or equal to 90 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 _____

**dexamethasone 8 mg** PO BID for 3 days, starting one day prior to treatment; patient must receive 3 doses prior to treatment

**Optional: Frozen gloves** starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing.

****Have Hypersensitivity Reaction Tray and Protocol Available****

CHEMOTHERAPY:

**DOCEtaxel 100 mg/$m^2$** x BSA =_____mg

☐ Dose Modification: _____% = _____ mg/$m^2$ x BSA = _____ mg

IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (Use Non-DEHP tubing)

## RETURN APPOINTMENT ORDERS

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

☐ Last Cycle. RTC in _____ weeks.

**CBC & Diff, Platelets** prior to each cycle
Prior to **Cycle 4**: **Bilirubin, ALT, GGT, Alk Phos**
If Clinically Indicated:

☐ **Tot. Prot** ☐ **Albumin** ☐ **Bilirubin** ☐ **GGT** ☐**Alk Phos.**
☐ **ALT** ☐ **LDH** ☐ **BUN** ☐ **Creatinine**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for further orders**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: