



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 and according to acceptable standards of care

PROTOCOL CODE: GIAJFFOX

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DOCTOR'S ORDERS

Ht _____ cm Wt _____ kg BSA _____ m²

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: _____ To be given: _____ Cycle #: _____ and _____

Date of Previous Cycle: _____

Delay treatment _____ week(s)

CBC & Diff, Platelets day of treatment

May proceed with doses as written if within 72 hours **ANC greater than or equal to $1.2 \times 10^9/L$, Platelets greater than or equal to $75 \times 10^9/L$**

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

NO ice chips

Other:

CHEMOTHERAPY: (Note – continued over 2 pages)

Repeat in two weeks Repeat in two and in four weeks

All lines to be primed with D5W

oxaliplatin 85 mg/m² x BSA = _____ mg

Dose Modification: _____ mg/m² x BSA = _____ mg

IV in 250 to 500 mL D5W over 2 hours*

*oxaliplatin and leucovorin may be infused over same two hour period by using a Y-site connector placed immediately before the injection site.

leucovorin 400 mg/m² x BSA = _____ mg IV in 250 mL D5W over 2 hours

***** SEE PAGE 2 FOR FLUOROURACIL CHEMOTHERAPY *****

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:



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DATE:

CHEMOTHERAPY: (Continued)

fluorouracil 400 mg/m² x BSA = _____ mg

Dose Modification: _____ mg/m² x BSA = _____ mg

IV push THEN

fluorouracil 2400 mg/m² or _____ mg/m² x BSA = _____ mg**

Dose Modification: _____ mg/m² x BSA = _____ mg**

IV over 46 hours in D5W to a total volume of 230 mL by continuous infusion at 5 mL/h via Baxter LV5 INFUSOR

** For 3000 to 5500 mg dose, **select INFUSOR per dose range below (doses outside dose banding range are prepared as ordered):**

| Dose Banding Range | Dose Band INFUSOR (mg) | Pharmacist Initial and Date |
|----------------------|-------------------------------|-----------------------------|
| Less than 3000 mg | Pharmacy to mix specific dose | |
| 3000 to 3400 mg | 3200 mg | |
| 3401 to 3800 mg | 3600 mg | |
| 3801 to 4200 mg | 4000 mg | |
| 4201 to 4600 mg | 4400 mg | |
| 4601 to 5000 mg | 4800 mg | |
| 5001 to 5500 mg | 5250 mg | |
| Greater than 5500 mg | Pharmacy to mix specific dose | |

RETURN APPOINTMENT ORDERS

Return in **two** weeks for Doctor and Cycle _____

Return in **four** weeks for Doctor and Cycles _____ & _____. Book chemo x 2 cycles.

Return in **six** weeks for Doctor and Cycles _____ & _____ & _____. Book chemo x 3 cycles.

Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets, Creatinine, Bili, ALT, Alk Phos, Sodium, Potassium, Mg, Ca prior to each cycle

INR weekly INR prior to each cycle

ECG CEA

Other tests:

Book for PICC assessment / insertion per Centre process

Book for IVAD insertion per Centre process

Weekly Nursing Assessment for (specify concern): _____

Consults:

See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: