



Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: GOOVVIN

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: _____				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets day of treatment May proceed with Day 1 doses as written if within 24 hours ANC greater than or equal to 1 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____ <input type="checkbox"/> hydrocortisone 100 mg IV PRN <input type="checkbox"/> Other: _____				
CHEMOTHERAPY: vinorelbine 25 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² /day x BSA = _____ mg IV in 50 mL NS over 6 minutes on Day 1 and 8. Flush vein with 75 to 125 mL NS following infusion of Vinorelbine.				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in three weeks for Doctor and Cycle # _____. Book chemo Day 1 and 8. <input type="checkbox"/> Last Cycle. Return in _____ week(s).				
CBC & Diff, Platelets prior to Day 1, each cycle. No labs required prior to Day 8 treatment. If clinically indicated: <input type="checkbox"/> CEA <input type="checkbox"/> CA 15-3 <input type="checkbox"/> CA-125 <input type="checkbox"/> CA 19-9 prior to treatment <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC: