BC Cancer Agency
CARE & RESEARCH

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: MOIT

DOCTOR'S ORDERS

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 and Platelets** day of treatment **OR**
☐ Use **CBC & Diff and Platelets** from (date) _____

May proceed with doses as written if **ANC greater than or equal to 0.5 x 10^9/L, Platelets greater than or equal to 40 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

CSF for: ☐ Cytology ☐ **Other**

CHEMOTHERAPY:

☐ **Methotrexate 12 mg** IT qs to 6 mL with *preservative-free NS* on (date) _____

OR

☐ **Thiotepa 12 mg** IT qs to 6 mL with *preservative-free NS* on (date) _____

OR

☐ **Cytarabine 50 mg** IT qs to 6 mL with *preservative-free NS* on (date) _____

Maximum 2 intrathecal chemotherapy treatments weekly (e.g., Monday and Thursday). *Give one drug each treatment.*

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor and Cycle _____.
Book chemo on _____.
☐ Last Cycle. Return in _____ week(s).

CSF cytology prior to cycle 1.
CBC & Diff, Platelets once weekly before treatment.
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

MEDICATION VERIFICATION CHECKS
Full Signatures Required

MEDICATION/ROUTE	DATE	SIGNATURES
Methotrexate 12 mg IT		RN:
OR		MD:
Thiotepa 12 mg IT		RN:
OR		MD:
Cytarabine 50 mg IT		RN:
		MD: