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: CNAJ12TZRT

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

For dual modality treatment: May proceed with doses as written if within 48 hours **ANC greater than or equal to 1.5 x 10^9/L, platelets greater than or equal to 100 x 10^9/L,** and if ordered, **ALT less than or equal to 2.5 x ULN, total bilirubin less than 25 micromol/L**

For adjuvant treatment: May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.5 x 10^9/L, platelets greater than or equal to 100 x 10^9/L, ALT less than or equal to 2.5 x ULN, total bilirubin less than 25 micromol/L and creatinine less than or equal to 2 x ULN,** and **Day 22 ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 50 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Hepatotoxicity** ☐ **Other Toxicity:** ____________________

Proceed with treatment based on blood work from ____________________

CHEMOTHERAPY:

Concomitant with RT (dual modality)

temozolomide 75 mg/m^2 x BSA = ________ mg PO 1 hour prior to RT especially in the first week of treatment, and in AM on days without RT until the end of RT **(max. 49 days)** starting on ________________.

(refer to Temozolomide Suggested Capsule Combination Table for dose rounding)

Adjuvant treatment starting 4 weeks after RT

temozolomide 150 mg/m^2 *or* ______ **mg/m^2** x BSA = _______ mg PO once daily x 5 days starting on _____________.

(refer to Temozolomide Suggested Capsule Combination Table for dose rounding)

RETURN APPOINTMENT ORDERS

☐ For dual modality treatment: Return in _____ week(s) for Doctor and Week ______.

☐ At completion of radiotherapy: Return in **four** weeks for Doctor and Cycle _______.
(Cycle 1 to start four weeks following RT.)

☐ Return in **three** weeks after start of RT for Doctor

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

☐ For dual modality treatment: **CBC & Diff, platelets,** weekly x ______ week(s) starting on ____________; and **ALT, total bilirubin before Week 1 and Week 4.**

☐ For chemotherapy alone: **CBC & Diff, platelets** prior to Day 1 and Day 22; and **creatinine, ALT, total bilirubin** prior to Day 1

If clinically indicated: ☐ **sodium** ☐ **potassium** ☐ **magnesium** ☐ **calcium**

☐ **random glucose**

☐ **CT** or ☐ **MRI head** (select one) in ________ weeks

☐ **Other tests:**

☐ **Consults:**

☐ **Change MRP to** ________________

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: