



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: GICAPOX

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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(s) #:		
Date of Previous Cycle: _____				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets day of treatment May proceed with doses as written if within 96 hours ANC greater than or equal to 1.2 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than 50 mL/minute				
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 _____.				
ondansetron 8 mg PO prior to treatment				
dexamethasone 8 mg or 12 mg (<i>circle one</i>) PO prior to treatment				
NO ice chips				
<input type="checkbox"/> Other: _____				
CHEMOTHERAPY: All lines to be primed with D5W <input type="checkbox"/> Repeat in three weeks				
oxaliplatin 130 mg/m ² x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg				
IV in 250 to 500 mL D5W over 2 hours				
To reduce incidence of vascular pain:				
<input type="checkbox"/> 250 mL total volume of D5W to be administered concurrently with oxaliplatin at a maximum rate of 125 mL/h				
<input type="checkbox"/> 500 mL total volume of D5W to be administered concurrently with oxaliplatin at a maximum rate of 250 mL/h				
capecitabine 1000 mg/m ² or _____ x BSA x (_____ %) = _____ mg PO BID x 14 days (refer to Capecitabine Suggested Tablet Combination Table for dose rounding)				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____				
<input type="checkbox"/> Return in six weeks for Doctor and Cycle _____ & _____. Book chemo x 2 cycles				
<input type="checkbox"/> Last Cycle. Return in _____ week(s)				
CBC & Diff, Platelets, Creatinine, Bilirubin, ALT, Alk Phos, Sodium, Potassium, Magnesium, Calcium prior to each cycle				
<input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle				
<input type="checkbox"/> ECG <input type="checkbox"/> CEA <input type="checkbox"/> CA 19-9				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Weekly Nursing Assessment for (specify concern): _____				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC: