

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: GIRCAP

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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	ven:			Cycle	#:	
Date of Previous Cycle:						
☐ Delay treatment week(s)						
☐ CBC & diff, platelets, creatinine day of treatn	nent					
May proceed with doses as written if within 96 hours ANC <u>greater than or equal to</u> 1.5 x 10 ⁹ /L, Platelets <u>greater than</u> or equal to 75 x 10 ⁹ /L, and Creatinine Clearance <u>greater than</u> 50 mL/minute						
Dose modification for: Hematology	Other To:	xicity				
Proceed with treatment based on blood work from						
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm						
CHEMOTHERAPY:						
capecitabine 1000 or 1250 mg/m² (select one) x BSA x (%) =mg PO BID x 14 days.						
(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)						
RETURN APPOINTMENT ORDERS						
☐ Return in three weeks for Doctor and oral cher☐ Last Cycle. Return in week(s)	no Cycle					
CBC & diff, platelets, creatinine prior to each cyc	cle					
☐ INR weekly ☐ INR prior to each cycle						
☐ Other tests:						
☐ Weekly Nursing Assessment						
☐ Consults:						
See general orders sheet for additional requ	uests.					
DOCTOR'S SIGNATURE:				s	IGNATU	/RES:
				ľ	C:	