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: LUAVVIN

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:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment ______ week(s)
☐ **CBC & Diff, Platelets** day of treatment
May proceed with doses as written if within 24 hours **ANC greater than or equal to 1 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** ______________________________
Proceed with treatment based on blood work from ____________________

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm ________________________.
☐ **Hydrocortisone 100 mg** IV prn
☐ **Other:**

CHEMOTHERAPY:

vinorelbine 30 mg/m²/day x BSA = ________ mg
☐ Dose Modification: ________% = ________ mg/m² x BSA = ___________ mg
IV in 50 mL NS over 6 minutes **Day 1 and Day 8**

Flush vein with 75 to 125 mL NS following infusion of vinorelbine.

DOSE MODIFICATION DAY 8:

vinorelbine 30 mg/m²/day x BSA = __________ mg
☐ Dose Modification: ________% = ________ mg/m² x BSA = ___________ mg
IV in 50 mL NS over 6 minutes **Day 8**

Flush vein with 75 to 125 mL NS following infusion of vinorelbine

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _______. Book chemo Day 1 and 8.
☐ Last Cycle. Return in _______ week(s).

CBC & Diff, Platelets prior to each treatment
If clinically indicated prior to each cycle: ☐ **Creatinine** ☐ **Bilirubin**
☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**