PROTOCOL CODE: BRAJCAP

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, creatinine** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 75 x 10^9/L, Creatinine Clearance greater than or equal to 50 mL/min.**

Dose modification for: ☐**Age/ECOG** ☐**Hematology** ☐**Other Toxicity**_____

Proceed with treatment based on blood work from_____

CHEMOTHERAPY:

capecitabine 1000 mg/m^2 or _____ **mg/m^2** x BSA x (_____%) = _____mg PO BID x 14 days on Days 1 to 14. (refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____

☐ Last Cycle. RTC in _____ week(s).

CBC & Diff, Platelets, Creatinine prior to each cycle.

If Clinically Indicated: ☐ **Albumin** ☐ **Bilirubin** ☐ **GGT** ☐**Alk Phos.**
☐ **ALT** ☐**LDH** ☐ **BUN**

☐ **Other tests:**

☐ **Weekly nursing assessment**

☐ **Consults:**

☐ **See general orders sheet for further orders**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: