

PROTOCOL CODE: BRAVCAP (PO)

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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 #:
Date of Previous Cycle: _____		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets, and Creatinine day of treatment May proceed with doses as written if within 96 hours ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than 50 mL/min. Dose modification for: <input type="checkbox"/> Age /ECOG <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____		
CHEMOTHERAPY:		
capecitabine 1000 mg/m² or 1250 mg/m² (circle one) 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		
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ weeks.		
CBC & Diff, Platelets, and Creatinine prior to each cycle If clinically indicated: <input type="checkbox"/> Tot. Prot <input type="checkbox"/> Albumin <input type="checkbox"/> Bilirubin <input type="checkbox"/> GGT <input type="checkbox"/> Alk Phos. <input type="checkbox"/> LDH <input type="checkbox"/> ALT <input type="checkbox"/> BUN <input type="checkbox"/> CA 15-3 <input type="checkbox"/> Other tests: <input type="checkbox"/> Weekly nursing assessment <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for further orders		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: