PROTOCOL CODE: GIAJRALOX

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 day of treatment
May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L and Creatinine clearance greater than or equal to 65 mL/min**

Dose modification for: ☐ **Hematology** ☐ **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** *(select one)* PO prior to treatment
NO ice chips
☐ **Other:**

CHEMOTHERAPY: ☐ **Repeat in three weeks** ☐ **Repeat in four weeks**

raltitrexed ☐ **3 mg/m^2** or ☐ _____ mg/m^2 (select one) x BSA = _____ mg IV in 100 mL NS over 15 minutes

oxaliplatin ☐ **130 mg/m^2** or ☐ _____ mg/m^2 (select one) x BSA = _____mg IV in 250 to 500 mL D5W over 120 minutes

Prior to starting oxaliplatin, flush lines with D5W (oxaliplatin is NOT compatible with NS)

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____
☐ Return in **four** weeks for Doctor and Cycle _____
☐ Return in **six** weeks for Doctor and Cycle _____ & _____. Book chemo x 2 cycles
☐ Return in **eight** weeks for Doctor and Cycle _____ & _____. Book chemo x 2 cycles
☐ Last cycle. Return in _____ week(s)

CBC & Diff, Platelets, Creatinine, Bili, ALT, Alk Phos, Sodium, Potassium, Mg, Ca prior to each cycle
☐ **ECG**
☐ **Other tests:**
☐ **Book for PICC assessment / insertion per Centre process**
☐ **Book for IVAD insertion per Centre process**
☐ **Weekly Nursing Assessment for (specify concern):** _____
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

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