PROTOCOL CODE: GIAVTZCAP

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, bilirubin, ALT, alk phos** 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 75 x 10^9/L, creatinine clearance greater than 50 mL/min, bilirubin less than 25 micromol/L, and ALT less than or equal to 2.5 x ULN**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity:** _____

Proceed with treatment based on blood work from _____

CHEMOTHERAPY:

capecitabine 750 mg/m^2 x BSA x (_____%) = _____mg PO BID **Days 1 to 14**

(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

temozolomide 200 mg/m^2 or **_____ mg/m^2**x BSA x (_____%) = _____mg PO daily **Days 10 to 14**

(refer to Temozolomide Suggested Capsule Combination Table for dose rounding)

RETURN APPOINTMENT ORDERS

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

☐ Last Cycle. Return in _____ week(s).

CBC & diff, platelets, creatinine, bilirubin, ALT, alk phos prior to each cycle

If clinically indicated: ☐ **electrolytes** ☐ **magnesium** ☐ **calcium** ☐ **glucose** ☐ **CgA** ☐ **24 Hr urine 5-HIAA**

☐ **INR** weekly ☐ **INR** prior to each cycle

☐ **Other tests:**

☐ **Weekly Nursing Assessment**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: