BC CANCER
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: CNAJTZRT

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

For dual modality treatment: May proceed with doses as written if within 48 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 if ordered, ALT less than or equal to 2.5 x ULN, total bilirubin less than 25 micromol/L**

For adjuvant 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, ALT less than or equal to 2.5 x ULN, total bilirubin less than 25 micromol/L and creatinine less than or equal to 2 x ULN,** and if **Day 22 ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 50 x 10^9/L**

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

Proceed with treatment based on blood work from _____

CHEMOTHERAPY:

Concomitant with RT (dual modality)

temozolomide 75 mg/m² x BSA = _____ mg PO 1 hour prior to RT especially in the first week of treatment, and in AM on days without RT until the end of RT **(max. 49 days)** starting on _____. (refer to Temozolomide Suggested Capsule Combination Table for dose rounding)

Adjuvant treatment starting 4 weeks after RT

temozolomide ☐ **150 mg/m²** *or* ☐ _____ **mg/m²** *(select one)* x BSA = _____ mg PO once daily x 5 days starting on _____. (refer to Temozolomide Suggested Capsule Combination Table for dose rounding)

RETURN APPOINTMENT ORDERS

☐ For dual modality treatment: Return in _____ week(s) for Doctor and Week _____.
☐ At completion of radiotherapy: Return in **four** weeks for Doctor and Cycle _____.
(Cycle 1 to start four weeks following RT.)
☐ Return in **three** weeks after start of RT for Doctor
☐ Last Cycle. Return in _____ week(s).

☐ For dual modality treatment: **CBC & Diff, platelets,** weekly x _____ week(s) starting on _____; and **ALT, total bilirubin before Week 1 and Week 4.**
☐ For chemotherapy alone: **CBC & Diff, platelets** prior to Day 1 and Day 22; and **creatinine, ALT, total bilirubin** prior to Day 1

If clinically indicated: ☐ **sodium** ☐ **potassium** ☐ **magnesium** ☐ **calcium**
☐ **random glucose**

☐ **CT** or ☐ **MRI head** (select one) in _____ weeks
☐ **Other tests:**
☐ **Consults:**
☐ **Change MRP to** _____
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: