PROTOCOL CODE: CNELTZRT

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

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/m^2 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 starting on _____.

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

Adjuvant treatment starting 4 weeks after RT

temozolomide 150 mg/m^2 *or* **_____ mg/m^2** 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.)

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

☐ For dual modality treatment: **CBC & Diff, platelets,** weekly x 4 week(s) starting on Day 8; and **ALT, total bilirubin before Week 3.**

☐ 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: