



Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: BRAVGEMD

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 day of treatment _____		
May proceed with doses as written Day 1 if within 96 hours ANC <u>greater than or equal to</u> 1.5 x 10⁹/L, Platelets <u>greater than</u> 100 x 10⁹/L May proceed with doses as written Day 8 if within 48 hours ANC <u>greater than or equal to</u> 1.2 x 10⁹/L, Platelets <u>greater than</u> 75 x 10⁹/L		
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on bloodwork from _____		
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____ dexamethasone 8 mg PO BID for 3 days, starting one day prior to DOCEtaxel treatment; patient must receive 3 doses prior to treatment Optional: Frozen gloves starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing. <input type="checkbox"/> Other: _____		
Have Hypersensitivity Reaction Tray and Protocol Available		
CHEMOTHERAPY: DOCEtaxel 75 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 100 to 500 mL NS (use non- DEHP bag) over 1 hour Day 1 only . (Use non DEHP tubing) gemcitabine 1000 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 250 mL NS over 30 minutes Day 1 and 8		
DOSE MODIFICATION IF REQUIRED ON DAY 8: gemcitabine 1000 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 250 mL NS over 30 minutes on Day 8		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____. Book Chemo room Day 1 & 8. <input type="checkbox"/> Last Cycle. Return in _____ weeks.		
CBC & Diff, Platelets prior to each cycle (Day 1 and 8) Prior to Cycle 4: Bilirubin, AST, ALT, GGT, Alk Phos If clinically indicated: <input type="checkbox"/> Tot. Prot <input type="checkbox"/> Albumin <input type="checkbox"/> Bilirubin <input type="checkbox"/> GGT <input type="checkbox"/> AST <input type="checkbox"/> Alk Phos. <input type="checkbox"/> LDH <input type="checkbox"/> ALT <input type="checkbox"/> BUN <input type="checkbox"/> Creatinine <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: