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: BRAJCAP

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** day of treatment

May proceed with doses as written if within 96 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 or equal to 50 mL/min.**

Dose modification for: ☐**Age/ECOG** ☐**Hematology** ☐**Other Toxicity**_____

Proceed with treatment based on blood work from_____

CHEMOTHERAPY:

capecitabine 1000 mg/m^2 or _____ **mg/m^2** x BSA x (_____%) = _____mg PO BID with food x 14 days on Days 1 to 14. (Round dose to nearest 150 mg).

RETURN APPOINTMENT ORDERS

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

☐ Last Cycle. RTC in _____ week(s).

CBC & Diff, Platelets, Creatinine prior to each cycle.

If Clinically Indicated: ☐ **Tot. Prot** ☐ **Albumin** ☐ **Bilirubin** ☐ **GGT** ☐**Alk Phos.** ☐ **ALT** ☐**LDH** ☐ **BUN**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for further orders**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: