



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: BRAJFECD

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 if within 96 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____		
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. ondansetron 8 mg PO prior to treatment dexamethasone 8 mg or 12 mg (circle one) PO prior to treatment <input type="checkbox"/> aprepitant 125 mg PO pre-chemotherapy on Day 1 and 80 mg PO post-chemotherapy once daily on Days 2 and 3 <input type="checkbox"/> prochlorperazine 10 mg PO prn <input type="checkbox"/> metoclopramide 10 mg PO prn <input type="checkbox"/> Hydrocortisone 100 mg IV PRN For DOCEtaxel cycles: Dexamethasone 8 mg PO bid for 3 days starting one day prior to DOCEtaxel. 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: epirubicin 100 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV push fluorouracil 500 mg/m² x BSA x = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV push cyclophosphamide 500 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 100 to 250 mL NS over 20 minutes to 1 hour OR DOCEtaxel 100 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing)		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s).		
CBC & Diff, Platelets prior to each cycle Prior to Cycle 4: Bilirubin, Alk Phos, AST, ALT If clinically indicated: <input type="checkbox"/> Bilirubin <input type="checkbox"/> Creatinine <input type="checkbox"/> Tot. Prot <input type="checkbox"/> Albumin <input type="checkbox"/> GGT <input type="checkbox"/> AST <input type="checkbox"/> LDH <input type="checkbox"/> ALT <input type="checkbox"/> Alk Phos <input type="checkbox"/> BUN <input type="checkbox"/> Muga Scan <input type="checkbox"/> Echocardiogram <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE: UC:

