# PROTOCOL CODE: GIRCAP



## 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, and Creatinine Clearance greater than 50 mL/minute**

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

**Proceed with treatment based on blood work from** _____

**PREMEDICATIONS:** Patient to take own supply. RN/Pharmacist to confirm _____.

**CHEMOTHERAPY:**

**capecitabine** ☐ **1250 mg/$m^2$** or ☐ _____ mg/$m^2$ (select one) x BSA x ( _____%) = _____mg PO BID x 14 days.

(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

## RETURN APPOINTMENT ORDERS

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

☐ Last Cycle. Return in _____ week(s)

**CBC & diff, platelets, creatinine** prior to each cycle

☐ **INR** weekly ☐ **INR** prior to each cycle

☐ **Other tests:**

☐ **Weekly Nursing Assessment**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

**DOCTOR'S SIGNATURE:**

**SIGNATURES:**

**UC:**