

PROTOCOL CODE: GUSCPERT

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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 $1.5 \times 10^9/L$, Platelets greater than or equal to $100 \times 10^9/L$, Creatinine Clearance greater than or equal to 60 mL/min 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 (<i>circle one</i>) PO prior to treatment <input type="checkbox"/> hydrocortisone 100 mg IV prior to etoposide on days 1 to 3 <input type="checkbox"/> diphenhydramine 50 mg IV prior to etoposide on days 1 to 3 <input type="checkbox"/> Other: _____		
Have Hypersensitivity Reaction Tray and Protocol Available		
CHEMOTHERAPY: CIS platin 25 mg/m ² /day or _____ mg/m ² /day x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 100 to 250 mL NS over 30 minutes Days 1 to 3 OR CARBO platin AUC=5 x (GFR + 25) = _____ mg IV in 100 to 250 mL NS over 30 minutes Day 1 etoposide 100 mg/m ² /day or _____ mg/m ² /day x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² /day x BSA = _____ mg IV in 250 to 1000 mL (non-DEHP bag) NS over 45 minutes to 1 hour 30 minutes Days 1 to 3 (use non-DEHP tubing with 0.2 micron in-line filter)		
STANDING ORDER FOR ETOPOSIDE DRUG REACTION: hydrocortisone 100 mg IV prn / diphenhydramine 50 mg IV prn		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____. Book chemo x 3 days. <input type="checkbox"/> Return in four weeks for Doctor and Cycle _____. Book chemo x 3 days. <input type="checkbox"/> Last Cycle. Return in _____ week(s).		
CBC & Diff, Platelets, Creatinine prior to each cycle If clinically indicated: <input type="checkbox"/> Bilirubin <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE: UC: