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 ☐ **1000** or ☐ **1250** 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: