BC CANCER
Provincial Health Services Authority

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: LYIT

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)

☐ Twice weekly Option: **CBC & Diff**, **Platelets, PTT, INR** prior to Days 1, 8 and 15 of treatment,
Platelets, PTT, INR prior to Days 4, 11, and 18 of treatment

☐ Weekly Option: **CBC & Diff**, **Platelets, PTT, INR** prior to Days 1, 8, 15, 22, 29 and 36 of treatment

☐ Single Dose Option: **CBC & Diff, Platelets, PTT, INR** once prior to treatment.

May proceed with doses as written if within 24 hours **ANC greater than or equal to 0.5 x 10^9/L** (when applicable)**, Platelets greater than or equal to 50 x 10^9/L, INR less than 1.5 and PTT less than or equal to ULN**

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

Proceed with treatment based on blood work from _____

INTRATHECAL (IT) CHEMOTHERAPY:

☐ **TWICE WEEKLY INTRATHECAL TREATMENTS**

methotrexate ____mg IT (standard dose 12 mg) qs to 6 mL with *preservative-free* NS on Days 1, 8 and 15.

cytarabine _____mg IT (standard dose 50 mg) qs to 6 mL with *preservative-free* NS on Days 4, 11 and 18.

OR

☐ **WEEKLY INTRATHECAL TREATMENTS**

methotrexate ____mg IT (standard dose 12 mg) qs to 6 mL with *preservative-free* NS on Days 1, 15 and 29.

cytarabine _____mg IT (standard dose 50 mg) qs to 6 mL with *preservative-free* NS on Days 8, 22 and 36.

OR

☐ **SINGLE DOSE INTRATHECAL TREATMENTS**

☐**methotrexate** _____mg IT (standard dose 12 mg) qs to 6 mL with *preservative-free* NS on date_____.

☐**cytarabine** _____mg IT (standard dose 50 mg) qs to 6 mL with *preservative-free* NS on date_____.

Bed rest for 30 minutes after procedure in supine position.

Refer to local guidelines for anticoagulation and antiplatelet therapy management

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

PROTOCOL CODE: LYIT

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in _____ weeks for Doctor and Cycle _____. ☐ Twice weekly Option: Book chemo on Days 1, 4, 8, 11, 15 and 18 every 3 weeks. ☐ Weekly Option: Book chemo on Days 1, 8, 15, 22, 29 and 36 every 6 weeks. ☐ Single Dose Option: Book chemo on date _____. ☐ Last Cycle. Return in _____ week(s).	
CSF cytology Prior to each treatment: **PTT, INR, Platelets** ☐ Twice weekly Option: **CBC & Diff, Platelets, PTT, INR** prior to Days 1, 8 and 15. ☐ Weekly Option: **CBC & Diff, Platelets, PTT, INR** prior to Days 1, 8, 15, 22, 29 and 36. ☐ Single Dose Option: **CBC & Diff, Platelets, PTT, INR** prior to treatment. ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

PROTOCOL CODE: LYIT

Date:						
TWICE WEEKLY INTRATHECAL TREATMENTS						
MEDICATION VERIFICATION CHECKS Full Signatures Required						
MEDICATION/ROUTE	**Day 1**	**Day 4**	**Day 8**	**Day 11**	**Day 15**	**Day 18**
DATE (dd/mm/yy)						
methotrexate 12 mg IT	(RN) (MD)	**Not Given**	(RN) (MD)	**Not Given**	(RN) (MD)	**Not Given**
cytarabine 50 mg IT	**Not Given**	(RN) (MD)	**Not Given**	(RN) (MD)	**Not Given**	(RN) (MD)

OR

Date:						
WEEKLY INTRATHECAL TREATMENTS						
MEDICATION VERIFICATION CHECKS Full Signatures Required						
MEDICATION/ROUTE	**Day 1**	**Day 8**	**Day 15**	**Day 22**	**Day 29**	**Day 36**
DATE (dd/mm/yy)						
methotrexate 12 mg IT	(RN) (MD)	**Not Given**	(RN) (MD)	**Not Given**	(RN) (MD)	**Not Given**
cytarabine 50 mg IT	**Not Given**	(RN) (MD)	**Not Given**	(RN) (MD)	**Not Given**	(RN) (MD)

OR

PROTOCOL CODE: LYIT

Date:		
SINGLE DOSE INTRATHECAL TREATMENTS		
MEDICATION VERIFICATION CHECKS Full Signatures Required		
MEDICATION/ROUTE	**DATE** (dd/mm/yy)	**SIGNATURES**
methotrexate 12 mg IT		**RN:**
		MD:
cytarabine 50 mg IT		**RN:**
		MD: