

**PROTOCOL CODE: SMMCCPE**

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<b>DOCTOR'S ORDERS</b>			Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form					
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>			
Date of Previous Cycle:					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff, Platelets</b> day of treatment May proceed with doses as written if within 96 hours <b>ANC greater than or equal to 1.5 x 10<sup>9</sup>/L, Platelets greater than or equal to 100 x 10<sup>9</sup>/L, Creatinine Clearance greater than or equal to 60 mL/minute (if using CISplatin)</b> Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ <b>Proceed with treatment based on blood work from _____</b>					
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.					
ondansetron 8 mg PO prior to treatment on Days 1 to 3 dexamethasone 8 mg or 12 mg ( <i>circle one</i> ) PO prior to treatment on Days 1 to 3 <input type="checkbox"/> hydrocortisone 100 mg IV prior to etoposide <input type="checkbox"/> diphenhydrAMINE 50 mg IV prior to etoposide <input type="checkbox"/> Other:					
<b>**Have Hypersensitivity Reaction Tray and Protocol Available**</b>					
<b>CHEMOTHERAPY:</b>					
<b>CISplatin 25 mg/m<sup>2</sup>/day</b> x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 100 to 250 mL NS over 30 minutes x <b>3 days</b> <b>OR</b> <b>CARBOplatin AUC 5 x (GFR + 25) = _____ mg</b> IV in 100 to 250 mL NS over 30 minutes <b>Day 1 only</b>  <b>etoposide 100 mg/m<sup>2</sup>/day</b> x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 250 to 1000 mL (non-DEHP bag) NS over 45 minutes to <b>1 hour 30 minutes</b> x <b>3 days</b> (use non-DEHP tubing with 0.2 micron in-line filter)					
<b>STANDING ORDER FOR ETOPOSIDE TOXICITY:</b>					
hydrocortisone 100 mg IV prn / diphenhydrAMINE 50 mg IV prn					
<b>RETURN APPOINTMENT ORDERS</b>					
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____. Book chemo x 3 days. <input type="checkbox"/> Last Cycle. Return in _____ week(s).					
<b>CBC &amp; Diff, Platelets, Creatinine</b> prior to each cycle If clinically indicated: <input type="checkbox"/> <b>Total Bilirubin</b> <input type="checkbox"/> <b>Other tests:</b>  <input type="checkbox"/> <b>Consults:</b>  <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>					
<b>DOCTOR'S SIGNATURE:</b>				<b>SIGNATURE:</b>	
				<b>UC:</b>	