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/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: SADTIC

DOCTOR'S ORDERS

Ht____________**cm** **Wt**____________**kg** **BSA**____________**m²**

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** 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 100 x 10^9/L**

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

Proceed with treatment based on blood work from ______________________________

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

dexamethasone 10 mg PO 30 to 60 minutes prior to treatment

and **select** ONE of the following:

☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment

☐ Other:

CHEMOTHERAPY:

dacarbazine 1.2 g/m² x BSA = __________ g

☐ Dose Modification: _________% = _________ g/m² x BSA = ____________ g

IV in 500 to 1000 mL NS over 1 to 2 hours.

RETURN APPOINTMENT ORDERS

☐ Return in ☐ **three** weeks or ☐ **four** weeks (select one) for Cycle _______.

☐ Last Cycle. Return in __________weeks.

CBC & Diff, BUN, Platelets, Creatinine, Alk Phos, gamma GT, SGOT, LD prior to each treatment.

☐ **CXR** ☐ **CT Scan:** ________________________

☐ **Other Tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: