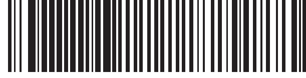
CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

EOX Regimen: **Oxaliplatin - EpiRUBicin - Capecitabine** (Part I)

Adult Chemotherapy- Medical Oncology

Advanced Esophagogastric Cancer Therapy



CC1300 0001 06 2017

Name:

HCN:

Date of Birth:

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY ________ Planned Administration Date: DD/MONTH/YYYY ________

Cycle______ of ______ **Cycle Duration: 21 days** Date of previous cycle:

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.5 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, Creatinine Clearance **greater than** 50 mL/minute, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.

PREMEDICATIONS:

☐ **Ondansetron 8 mg PO**

☐ **Dexamethasone 8 mg PO**

☐ Other: ____

DD/MONTH/YYYY

Authorized Prescriber: ____________________ Date: ____________________Time: __________

Authorized Prescriber's Signature: ______________________________ ID #: ______________________

Nurse's Name: ____________________ Date: DD/MONTH/YYYY ________ Time: __________

Nurse's Signature: ______________________________

THIS IS A CONTROLLED DOCUMENT; PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION. USER WILL BE SOLELY RESPONSIBLE FOR VERIFYING ITS CURRENCY AND ACCURACY.

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EOX Regimen:
Oxaliplatin - EpiRUBicin - Capecitabine (Part II)

Adult Chemotherapy- Medical Oncology

Advanced Esophagogastric Cancer Therapy

Name:

HCN:

Date of Birth:

CC1300 0001 06 2017

Weight: ____________kg Height:________________cm Body Surface Area (BSA) = ____________________

CHEMOTHERAPY: (FOR HOSPITAL PHARMACY)

☐ **Oxaliplatin 130 mg/m²** X BSA = ________mg IV in 500 mL D5W over 120 minutes on Day 1

☐ Dose modification: **130 mg/m²** X BSA - ______% = ________mg IV in 500 mL D5W over 120 minutes on Day 1

☐ **EpiRUBicin 50 mg/m²** X BSA = ___________ mg IV push on Day 1

☐ Dose modification: **50 mg/m²** X BSA - _________% = ___________ mg IV push on Day 1

CHEMOTHERAPY: (FOR COMMUNITY PHARMACY)

☐ **Capecitabine 625 mg/m²** X BSA = _______mg PO bid with food on Days 1 to 21

☐ Dose modification: **625 mg/m²** X BSA - ______% = _______mg PO bid with food on Days 1 to 21

This prescription is NOT eligible for medication management by a pharmacist.

Authorized Prescriber: __________________________ Date: DD/MONTH/YYYY Time: _________

Authorized Prescriber's Signature: _________________________________ ID #: _____________________________

Nurse's Name: ____________________________ Date: DD/MONTH/YYYY Time: _________

Nurse's Signature: ____

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