CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

DOCEtaxel-Capecitabine **1000** Regimen:

DOCEtaxel-Capecitabine

(Part I)

Adult Chemotherapy- Medical Oncology

Metastatic Esophagogastric Adenocarcinoma Therapy

CC1440 0015 06 2017

Name:

HCN:

Date of Birth:

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

Allergies: ☐ **No Known**

Date: __DD/MONTH/YYYY_____ Planned Administration Date: ____DD/MONTH/YYYY_____

Cycle_____ of _____ **Cycle Duration: 21 days** Date of previous cycle: _____DD/MONTH/YYYY__

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 (FOR COMMUNITY PHARMACY):

☐ **Dexamethasone 8 mg PO bid x 3 days starting the day before chemotherapy**

(Patient must receive a minimum of three doses prior to receiving treatment);

☐ RN to confirm _____, *INITIALS*

Authorized Prescriber: _____ Date: ____DD/MONTH/YYYY_____Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: _____DD/MONTH/YYYY_____ Time: _____

Nurse's Signature: _____

Name:

HCN:

Date of Birth:

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CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **DOCEtaxel 75 mg/m²** X BSA = _____ mg IV in 250 mLs NS (non-PVC bag)
over 60 minutes on Day 1 (doses greater than 185 mg must be diluted in 500 mLs NS)

☐ **Dose modification: 75 mg/m²** X BSA - _____% = _____ mg IV in 250 mLs NS (non-PVC bag)
over 60 minutes on Day 1

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **Capecitabine 1000 mg/m²** X BSA = _____mg PO bid with food on Days 1 to 14

☐ Dose modification: **1000 mg/m²** X BSA - _____% = _____mg PO bid with food on Days 1 to 14

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: _____