

Name: _____

HCN: _____

Date of Birth: _____



CC1490 0020 08 2016

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
 28 days

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** $1.5 \times 10^9/L$ and platelets **greater than or equal to** $100 \times 10^9/L$, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS:

Metoclopramide 10 mg PO
 Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

Raltitrexed $3 \text{ mg}/\text{m}^2$ X BSA= _____ mg IV in 100 mLs NS over 15 minutes on Day 1
 Dose modification: **$3 \text{ mg}/\text{m}^2$** X BSA - _____ % = _____ mg IV in 100 mLs NS over 15 minutes on Day 1

Authorized Prescriber: _____ Date: DD/MONTH/YYYY 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.