CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

Raltitrexed - Oxaliplatin Regimen:

Raltitrexed – Oxaliplatin (Part I)

Adult Chemotherapy- Medical Oncology

Metastatic Colorectal Cancer Therapy

CC1500 0021 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** ☐ **28 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, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS:

☐ **Ondansetron 8mg PO**

☐ **Dexamethasone 8mg PO** ☐ **Other:** _____

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

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

Raltitrexed - Oxaliplatin Regimen:

Raltitrexed – Oxaliplatin (Part II)

Adult Chemotherapy- Medical Oncology

Metastatic Colorectal Cancer Therapy

CC1500 0021 06 2017

Name:

HCN:

Date of Birth:

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **Raltitrexed 3 mg/m^2** X BSA= _____mg IV in 100 mLs NS over 15 minutes on Day 1

☐ Dose modification: **3 mg/m^2** X BSA - _____% = _____ mg IV in 100 mLs NS over 15 minutes on Day 1

(Prior to starting Oxaliplatin, flush lines with D5W- Oxaliplatin not compatible with NS)

☐ **Oxaliplatin 130 mg/m^2** X BSA = _____mg IV in 500 mL D5W over 120 minutes on Day 1

☐ Dose modification: **130 mg/m^2** X BSA - _____% = _____mg IV in 500 mL D5W over 120 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: _____