



Doctor's Order Sheet
Irinotecan **350** Regimen:
Irinotecan

Adult Chemotherapy- Medical Oncology
Metastatic Colorectal Cancer



CC1510 0022 06 2018

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** $1.5 \times 10^9/L$ and platelets **greater than or equal to** $100 \times 10^9/L$, Bilirubin **less than or equal to** 35 micromol/L, otherwise notify Medical Oncologist.

- LFT's assessed.

PREMEDICATIONS:

Ondansetron 16 mg PO

Dexamethasone 8 mg PO

Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

Irinotecan $350 \text{ mg/m}^2 \times \text{BSA} =$ _____ mg IV in 500 mL D5W over 90 minutes on Day 1

Dose modification: $350 \text{ mg/m}^2 \times \text{BSA} -$ _____ % = _____ mg IV in 500 mL D5W
over 90 minutes on Day 1

HYDRATION/SUPPORTIVE CARE:

Atropine 0.4 mg intravenous prn for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis, or flushing.

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.