



CC2380 0109 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 (Day 1): DD/MONTH/YYYY
 Cycle _____ of _____ **Cycle Duration: 42 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** $75 \times 10^9/L$, 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 **100 mg/m²** X BSA = _____ mg IV in 500 mL D5W over 90 minutes on Day 1,8,15 and 22
- Dose modification: **100 mg/m²** X BSA - _____ % = _____ mg IV in 500 mL D5W over 90 minutes on Day 1,8,15 and 22

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: _____

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