CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

Irinotecan**100 (2 of 3)** Regimen: **Irinotecan**

Adult Chemotherapy- Medical Oncology
Metastatic Colorectal Cancer

CC2360 0107 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: 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** 75 X 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 and 8

☐ Dose modification: **100 mg/m²** X BSA - _____% = _____ mg IV in 500 mL D5W over 90 minutes on Day 1 and 8

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: _____