CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

Capecitabine **1000** Regimen:
Capecitabine

Adult Chemotherapy- Medical Oncology
Colorectal Cancer

CC2340 0105 09 2016

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 X 10^9/L and platelets **greater than or equal to** 75 X 10^9/L, Creatinine Clearance **greater than** 50 mL/minute, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **Capecitabine 1000 mg/m^2** X BSA = _____mg PO bid with food on Days 1 to 14

☐ Dose modification: **1000 mg/m^2** X BSA - _____% = _____mg PO bid with food on Days 1 to14

Mitte: _____ x 500 mg tablets and _____ x 150 mg tablets (_____ days supply)

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.