CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth

Doctor's Order Sheet

fluorouracil 500 - leucovorin calcium 20 Regimen

ARIA Protocol Name: Fluorouracil 500 Leucovorin 20

Adult Chemotherapy - Medical Oncology

Recurrent or Metastatic Nasopharyngeal Cancer

CC7070 0527 11/2024

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY

Cycle_____ of _____ **Cycle Duration: 14 days**

Planned Administration Date: DD/MONTH/YYYY

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
- LFTs and Bilirubin assessed
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **metoclopramide 10 mg PO** pre chemotherapy on day 1 and 8

☐ Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **leucovorin calcium 20 mg/m²** X BSA = _____ **mg**

IV push on days 1 and 8

☐ **fluorouracil 500 mg/m²** X BSA = _____**mg**

☐ Dose modification: **fluorouracil 500 mg/m²** X BSA - _____% = _____**mg**

IV push on days 1 and 8

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

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.