CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

FOLFIRI Regimen:

Irinotecan - Fluorouracil – Leucovorin (Part I)

Adult Chemotherapy- Medical Oncology
Metastatic Colorectal Carcinoma

CC1550 0026 06 2018

Name:

HCN:

Date of Birth:

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY

Planned Administration Date: DD/MONTH/YYYY

Cycle_____ of _____ **Cycle Duration: 14 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, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.

PREMEDICATIONS:

☐ **Ondansetron 16 mg PO**

☐ **Dexamethasone 8 mg PO**

☐ Other: _____

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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Doctor's Order Sheet

FOLFIRI Regimen:

Irinotecan - Fluorouracil – Leucovorin (Part II)

Adult Chemotherapy- Medical Oncology

Metastatic Colorectal Carcinoma

CC1550 0026 06 2018

Name:

HCN:

Date of Birth:

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **Irinotecan 180 mg/m²** X BSA = _____ mg IV in 500 mL D5W over 90 minutes on Day 1

☐ Dose modification: **180 mg/m²** X BSA - _____% = _____ mg IV in 500 mL D5W over 90 minutes on Day 1

☐ **Leucovorin 400 mg/m²** X BSA= _____mg IV in 250 mL D5W over 90 minutes on Day 1

(Irinotecan and Leucovorin may be infused concurrently)

☐ **Fluorouracil 400 mg/m²** X BSA= _____mg

☐ Dose modification: **400 mg/m²** X BSA - _____% = _____mg IV push on Day 1, **THEN**

☐ **Fluorouracil 2400 mg/m²** X BSA=_____mg in D5W by continuous IV over 46 hours

☐ Dose modification: **2400 mg/m²** X BSA - _____% = _____mg in D5W by continuous IV over 46 hours

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: _____