CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

FOLFOX **85** Regimen: **Oxaliplatin – Fluorouracil – Leucovorin** (Part I)

Adult Chemotherapy- Medical Oncology

Adjuvant Colorectal Carcinoma

CC1570 0028 06 2017

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** 1.2 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 8 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: _____

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

FOLFOX **85** Regimen: **Oxaliplatin – Fluorouracil – Leucovorin** (Part II)

Adult Chemotherapy- Medical Oncology

Adjuvant Colorectal Carcinoma

CC1570 0028 06 2017

Name:

HCN:

Date of Birth:

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY)

☐ **Oxaliplatin 85 mg/m²** X BSA = _____ mg IV in 500 mL D5W over 120 minutes on Day 1

☐ Dose modification: **85 mg/m²** X BSA - _____% = _____ mg IV in 500 mL D5W over 120 minutes on Day 1

(Oxaliplatin and Leucovorin may be infused over the same two hour period)

☐ **Leucovorin 400 mg/m²** X BSA= _____mg IV in 250 mL D5W over 120 minutes on Day 1

☐ **Fluorouracil 400 mg/m²** X BSA= _____mg IV push on Day 1

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

☐ **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

Authorized Prescriber: _____ Date: _____Time: _____
DD/MONTH/YYYY

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: _____ Time: _____
DD/MONTH/YYYY

Nurse's Signature: _____