

Doctor's Order Sheet

FOLFOX **85** Regimen:

Oxaliplatin – Fluorouracil – Cancer Care Program Leucovorin (Part I)

Adult Chemotherapy- Medical Oncology Adjuvant Colorectal Carcinoma



CC1570 0028 06 2013

Name:		
HCN:		
Date of Birth:		

Date:DD/MONTH/YYY	Allergies:		☐ No Know
MAY PROCEED WITH DOSES AS WRITTEN IF: ANC greater than or equal to 1.2 X 10°/L and platelets greater than or equal to 75 X 10°/L, otherwise notify Medical Oncologist. LFT's and Bilirubin assessed. PREMEDICATIONS: Ondansetron 8 mg PO Dexamethasone 8 mg PO Other: Date: DD/MONTH/YYYYTime:		Planned Administration Date:	DD/MONTH/YYYY
Authorized Prescriber: Date: Date: DDMONTH/YYYY Time: Authorized Prescriber's Signature: In the row of	Cycle of Cycle Duration: 14 days	Date of previous cycle:	DD/MONTH/YYYY
otherwise notify Medical Oncologist. • LFT's and Bilirubin assessed. PREMEDICATIONS: □ Ondansetron 8 mg PO □ Dexamethasone 8 mg PO □ Other: □ Other: Authorized Prescriber: □ Date: □ DD/MONTH/YYYYTime:	MAY PROCEED WITH DOSES AS WRITTEN IF:		
LFT's and Bilirubin assessed. PREMEDICATIONS: Ondansetron 8 mg PO Dexamethasone 8 mg PO Other: Authorized Prescriber: Date: Date: DD/MONTH/YYY Time: Authorized Prescriber's Signature: ID #:	 ANC greater than or equal to 1.2 X 10⁹/L and plate 	elets greater than or equal to 75	X 10 ⁹ /L,
PREMEDICATIONS: Ondansetron 8 mg PO Other: Other: Date: DD/MONTH/YYYY Time: Authorized Prescriber's Signature: ID #:	otherwise notify Medical Oncologist.		
□ Ondansetron 8 mg PO □ Dexamethasone 8 mg PO □ Other: □ Other: □ Date: □ DD/MONTH/YYYYTime:	 LFT's and Bilirubin assessed. 		
Dexamethasone 8 mg PO Other: Authorized Prescriber: Date: Date: DD/MONTH/YYYY Time: JD #: JD #:	PREMEDICATIONS:		
Other:	☐ Ondansetron 8 mg PO		
Authorized Prescriber: Date:DD/MONTH/YYYYTime: Authorized Prescriber's Signature: ID #:	☐ Dexamethasone 8 mg PO		
Authorized Prescriber: Date: Time: Authorized Prescriber's Signature: ID #:	☐ Other:		
Authorized Prescriber's Signature: ID #:			
Authorized Prescriber's Signature: ID #:			
Authorized Prescriber's Signature: ID #:			
Authorized Prescriber's Signature: ID #:			
Authorized Prescriber's Signature: ID #:			
Authorized Prescriber's Signature: ID #:			
Authorized Prescriber's Signature: ID #:			
	Authorized Prescriber: D	ate: DD/MONTH/YYYY	Time:
	with arized Duscovikovic Cismotowe	ID #.	
Nurse's Name: Date: DD/MONTH/YYYY Time:	Authorized Prescriber's Signature:	ID #	
	Nurse's Name: Date:	DD/MONTH/YYYY T	ime:

THIS IS A CONTROLLED DOCUMENT; PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION. USER WILL BE SOLELY RESPONSIBLE FOR VERIFYING ITS CURRENCY AND ACCURACY.

Page 1 of 2 CP-0028 2017/06



Doctor's Order Sheet

Care FOLFOX 85 Regimen:

Oxaliplatin – Fluorouracil –

Name:

HCN:

Date of Birth:

Leucovorin (Part II)

Adult Chemotherapy- Medical Oncology Adjuvant Colorectal Carcinoma



CC1570 0028 06 2017

Weight:	kg	Height:	cm	Body Surface Area	(BSA) =	
CHEMOTHER ☐ Oxaliplatin	•		,	D5W over 120 minutes	on Day 1	
				mg IV in 500 mL [
over 120 mi	nutes on Day 1					
(Oxaliplatin ar	nd Leucovorin r	nay be infused	over the same two h	our period)		
☐ Leucovorin	400 mg/m² X E	BSA=	mg IV in 250 mL [D5W over 120 minutes	on Day 1	
☐ Fluorourac	il 400 mg/m² X	(BSA=	mg IV push on	Day 1		
☐ Dose modifi	ication: 400 mg	/m ² X BSA	% =	mg IV push on Da	y 1	
☐ Fluorourac	il 2400 mg/m²	X BSA=	mg in D5W by	continuous IV over 46	hours	
☐ Dose modifi	cation: 2400 m	g/m² X BSA	% =	mg in D5W		
by continuo	ous IV over 46 h	nours				
Authorized Pres	criber:		Date:	DD/MONTH/YYYY	Time:	
Authorized Pres	criber's Signatu	ıre:		ID #:		
Nurse's Name:			Date:	DD/MONTH/YYYY	Time:	
Nurse's Signatu	re:					

THIS IS A CONTROLLED DOCUMENT; PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION. USER WILL BE SOLELY RESPONSIBLE FOR VERIFYING ITS CURRENCY AND ACCURACY.

Page 2 of 2 CP-0028 2017/06