Evaluation of the risk of toxicity to Fluoropyrimidines and Determination of 5-fluorouracil

eurofins | Biomnis

INTERNATIONAL DIVISION - Tel.: **+33 (0)4 72 80 23 85** - Fax: **+33 (0)4 72 80 73 56** - E-mail: **international@biomnis.com**

The blood must be drawn before any chemotherapy or at least 1 week after the last course of treatment.

REQUESTING CLINICIAN

Surname: .....
First name(s): .....
Institution/Service: .....
Adress: .....
Post code: ⌊_⌊_⌊_⌊_⌊_⌋ City: .....
Country: .....
Tel.: ..... Fax: .....

Customer Identification

Compulsory Stick your laboratory identification sticker here

Sample Date: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋

PATIENT

☐ Mrs ☐ Mr Gender: ☐ F ☐ M
Surname: .....
First name(s): .....
Name of birth: .....
Date of birth: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌊_⌊_⌋
Adress: .....
Post code: ⌊_⌊_⌊_⌊_⌊_⌋ City/Country: .....
☐ Out-patient ☐ Hospitalised

SAMPLE SITE *(samples must be drawn from peripheral sites only)*

☐ Port-a-cath / implantable site ☐ Infusion
☐ Other: .....

PRE-ANALYTICAL INFORMATION:

Time of sampling: ⌊_⌊_⌋ h ⌊_⌊_⌋
Time of freezing *(Lithium-heparin plasma)* : ⌊_⌊_⌋ h ⌊_⌊_⌋
Time of refrigeration *(EDTA whole blood)* : ⌊_⌊_⌋ h ⌊_⌊_⌋

CLINICAL DETAILS *(Essential data for therapeutic advice and dose calculation)*

Patient: Weight: ..... kg Height: ..... cm
Primary location of the tumour: .....

Origin: ☐ Europe ☐ North Africa ☐ Asia
☐ Sub-Saharan Africa and West Indies
☐ Other (i.e. mixed race): .....

Previous chemotherapy: ☐ Yes ☐ No
Presence of toxicity: ☐ Yes ☐ No
If yes: **Grade of toxicity (1 to 5)** : ⌊_⌋ **Type of toxicity:** ☐ Haematological ☐ Diarrhoea ☐ Mucitis ☐ HFS ☐ Coma
Radiotherapy concomitant to chemotherapy: ☐ Yes ☐ No

Scheduled date of chemotherapy: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋

REQUEST FOR ANALYSES

☐ **EVALUATION OF THE RISK OF TOXICITY TO FLUOROPYRIMIDINES (5-FU$^{ODPM\ TOX\ TM}$) (code: 5FUTO)**
Pre-therapeutic screening for DPD deficiency by genotyping and phenotyping (DPYD - UH_2/U)

☐ **UGT1A1 - EVALUATION OF THE RISK OF TOXICITY TO IRINOTECAN (code: UGT1A)**
Study of the polymorphism of the UGT1A1 promoter gene

Date of request: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋
Protocol in progress / scheduled: .....
Duration of 5-FU infusion:
☐ 4h ☐ 2x23h ☐ 46h ☐ 96h ☐ 120h ☐ Other: ..... h
Or oral 5-FU prodrug:
☐ Capecitabine ☐ S1 ☐ Other : .....
Associated drugs:
☐ Irinotecan ☐ Oxaliplatine ☐ Carboplatin
☐ Cisplatin ☐ Bevacizumab ☐ Cetuximab
☐ Trastuzumab ☐ Panitumumab ☐ Other: .....
Documents to be included:
- Declaration of consultation and consent

☐ **DETERMINATION OF 5-FLUOROURACIL FOR DOSE ADJUSTMENT (5-FU$^{ODPM\ PROTOCOL\ TM}$) (code: 5FUPR)**
Pharmacokinetic monitoring of chemotherapies at 5-FU

Date of request: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋
Date and time of start of 5-FU infusion:
⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋ at ⌊_⌊_⌋ h ⌊_⌊_⌋ min
Date and time of end of 5-FU infusion:
⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋ à ⌊_⌊_⌋ h ⌊_⌊_⌋ min
Dose of 5-FU: ..... mg **Folinic acid:** ..... mg
Associated drugs:
☐ Irinotecan ☐ Oxaliplatin ☐ Carboplatin
☐ Cisplatin ☐ Bevacizumab ☐ Cetuximab
☐ Trastuzumab ☐ Panitumumab ☐ Other: .....
Documents to be included:
- Chemotherapy plan
- Pharmacokinetic monitoring sheet

Comments / Observations: .....
.....
.....

K23-24B-INTGB - June 2018