(Place Patient Identification Sticker Here)

Methodist Le Bonheur Healthcare

Physician Orders ADULT

Order Set: 7 + 3 (DAUNOrubicin)

Diagnosis : AML

Height:_____cm	Weight:_____kg		Cycle:	Of :
Actual BSA:	m2	Treatment BSA: m2	Day/Wk:	Freq:
Allergies:		[ ] No known allergies		
[ ]Medication allergy(s):_____				
[ ] Latex allergy	[ ]Other:			

Patient Care				
[ ]	Nursing Communication	T;N, Do not exceed a treatment BSA of_____m2		
[ ]	Nursing Communication	T;N, May hold hydration during chemotherapy infusion		
[ ]	Nursing Communication	T;N, Verify patient has had MUGA or ECHO to r/o Cardiac dysfunction prior to chemotherapy		
Continuous Infusions				
Pre Hydration				
[X]	Normal Saline	1,000 mL, IV, Routine, mL/hr		
Medications				
CHEMOTHERAPY				
	Drug (generic) & solution (optional)	**Intended Dose**	**Actual Dose**	**Route, Infusion, Frequency and total doses**
[X]	**cytarabine**	**100 mg/m^2**		**Continuous Infusion, Infuse over 24 hours, Daily on DAYS 1-7**
[X]	**DAUNOrubicin**	**60 mg/m^2**		**IV Push, q 24h on DAYS 1-3**
Acute Emesis Prophylaxis (may undergo therapeutic interchange)				
NOTE: Administer intial doses at least 30-60 minutes prior to chemotherapy				
[X]	ondansetron	12 mg, Injection, IV Piggyback, qDay, on DAYS 1-7		
[X]	dexamethasone	8 mg, Injection, IV Push, Q Day , on DAYS 1 - 3		
[X]	prochlorperazine	10 mg, Tab, PO, q6h, PRN Nausea/Vomiting		
[X]	prochlorperazine	10 mg, Injection, IV Push, q6h, PRN Nausea/Vomiting , Comment : if unable to take PO		
Delayed Emesis Prophylaxis				
NOTE: Start on Day				
[ ]	Dexamethasone	8 mg, Tab, PO, bid, for 2 days Comment: Day 1 and 2 of delayed emesis prophylaxis		
[ ]	Dexamethasone	4 mg, Tab, PO, bid, for 2 days, Comment: Day 3 and 4 of delayed emesis prophylaxis		
[ ]	Dexamethasone	Dose:_____mg, Tab, PO, Frequency:_____, Duration: _____		
[ ]	Ondansetron	Dose:_____mg, Tab, PO, Frequency:_____, Duration: _____		
[ ]	Metoclopramide	Dose:_____mg, Tab, PO, Frequency:_____, Duration: _____		
[ ]	Prochlorperazine	Dose:_____mg, Tab, PO, Frequency:_____, Duration: _____		
Consults/Notifications				
[ ]	Notify Physician- Once	T;N, Who: , For: if BSA exceeds 2 m^2		

Date **Time** **Physician's Signature** **MD Number**