

Physician Orders ADULT
Order Set: ABVD
Diagnosis : Hodgkins Lymphoma

Height: _____ cm		Weight: _____ kg		Cycle: _____ Of : _____	
Actual BSA: _____ m ²		Treatment BSA: _____ m ²		Day/Wk: _____ Freq: _____	
Allergies:					
<input type="checkbox"/> Medication allergy(s): _____		<input type="checkbox"/> No known allergies			
<input type="checkbox"/> Latex allergy		<input type="checkbox"/> Other: _____			
Vital Signs					
<input type="checkbox"/>	Vital Signs	T;N, q15 min for 1 hour, Comment: once bleomycin test dose has been administered			
Patient Care					
<input type="checkbox"/>	Nursing Communication	T;N, Do not exceed a treatment BSA of _____ m ²			
<input type="checkbox"/>	Nursing Communication	T;N, May hold hydration during chemotherapy infusion			
<input type="checkbox"/>	Nursing Communication	T;N, Verify patient has had MUGA or ECHO to r/o Cardiac dysfunction prior to chemotherapy			
Medications					
<input checked="" type="checkbox"/>	EPINEPHrine 1:1000	1mg/mL , Injection, IV Push, (for 1 dose) , PRN bleomycin reaction			
Pre Medications					
NOTE: Administer the below TEST DOSE before the first dose of bleomycin					
<input checked="" type="checkbox"/>	bleomycin	2 units, IV, IV Push, TEST DOSE , Wait a minimum of 1 hour before administering the remainder of dose			
CHEMOTHERAPY					
	Drug(generic) & solution (optional)	Intended Dose	Actual Dose	Route, Infusion, Frequency and total doses	
<input checked="" type="checkbox"/>	DOXOrubicin	25 mg/m²		IV Push, Once on DAYS 1 and 15	
<input checked="" type="checkbox"/>	bleomycin	10 units/m²		IV Piggyback, Infuse over 60 min, Once on DAYS 1 and 15	
<input checked="" type="checkbox"/>	vinBLASine	6 mg/m²		IV Push, Once on DAYS 1 and 15	
<input checked="" type="checkbox"/>	dacarbazine	375 mg/m²		IV Piggyback, Infuse over 60 min, Once on DAYS 1 and 15	
Acute Emesis Prophylaxis (may undergo therapeutic interchange)					
NOTE: Administer intial doses at least 30-60 minutes prior to chemotherapy					
<input checked="" type="checkbox"/>	ondansetron	12 mg, Injection, IV Piggyback, qDay, on DAYS 1 and 15			
<input checked="" type="checkbox"/>	dexamethasone	12 mg, Injection, IV Piggyback, qDay, on DAYS 1 and 15			
<input checked="" type="checkbox"/>	prochlorperazine	10 mg, Tab, PO, q6h, PRN Nausea/Vomiting			
<input checked="" type="checkbox"/>	prochlorperazine	10 mg, Injection, IV Push, q6h, PRN Nausea/Vomiting , Comment : if unable to take PO			
Consults/Notifications					
<input type="checkbox"/>	Notify Physician- Once	T;N, Who: _____, For: if BSA exceeds 2 m ²			
<input type="checkbox"/>	Notify Physician- Once	T;N, Who: _____, For: hypotension, dyspnea and O2 saturation less than 92%			

Date

Time

Physician's Signature

MD Number

