attach patient label here

Methodist Le Bonheur Healthcare

Physician Orders ADULT

Order Set: D-Pace

Diagnosis : Multiple Myeloma

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				
[ ]	Normal Saline	1,000 mL, IV, Routine, ____mL/hr , Start 4 hours prior to chemotherapy and continue for at least 24 hours after CISplatin infusion is complete		
Medications				
[X]	dexamethasone	40 mg, Tab, PO, qDay, on DAYS 1-4		
CHEMOTHERAPY				
	Drug (generic) & solution (optional)	**Intended Dose**	**Actual Dose**	**Route, Infusion, Frequency and total doses**
[X]	**CISplatin**	**10 mg/m^2**		**Continuous Infusion, Infuse over 24 hours, Daily on DAYS 1- 4**
[X]	**DOXOrubicin**	**10 mg/m^2**		**Continuous Infusion, Infuse over 24 hours, Daily on DAYS 1- 4**
[X]	**cyclophosphamide**	**400 mg/m^2**		**Continuous Infusion, Infuse over 24 hours, Daily on DAYS 1- 4**
[X]	**etoposide**	**40 mg/m^2**		**Continuous Infusion, Infuse over 24 hours, Daily on DAYS 1- 4**
[X]	**dexamethasone**	**40 mg**	**40 mg**	**PO, q24h on DAYS 1-4**
NOTE: Mix cisplatin,cyclophosphamide,and etoposide together in 1 L bag				
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 1-4		
[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		
Consults/Notifications				
[ ]	Notify Physician- Once	T;N, Who: _____, For: if BSA exceeds 2 m^2		

_____ _____ _____ _____

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