

(Place Patient Identification Sticker Here)



## Physician Orders ADULT

### Order Set: BMT Triple Intrathecal

#### Diagnosis:

Height: _____ cm	Weight: _____ kg	Cycle: _____ Of : _____		
Actual BSA: _____ m2	Treatment BSA: _____ m2	Day/Wk: _____ Freq: _____		
<b>Allergies:</b> <input type="checkbox"/> No known allergies				
<input type="checkbox"/> Medication allergy(s): _____				
<input type="checkbox"/> Latex allergy <input type="checkbox"/> Other: _____				
<b>Patient Care</b>				
<input checked="" type="checkbox"/> Nursing Communication	I;N, Intrathecal chemotherapy to be administered by physician			
<b>Medications</b>				
<b>CHEMOTHERAPY</b>				
	<b>Drug (generic)</b>	<b>Intended Dose</b>	<b>Actual Dose</b>	<b>Route, Infusion, Frequency and total doses</b>
<input checked="" type="checkbox"/>	<b>Methotrexate</b>	<b>10 mg</b>	<b>10 mg</b>	Intrathecal, ONCE, on Day Mix in the same syringe. Total Volume: 5 ml
<input checked="" type="checkbox"/>	<b>Hydrocortisone</b>	<b>50 mg</b>	<b>50 mg</b>	
<input checked="" type="checkbox"/>	<b>Cytarabine</b>	<b>50 mg</b>	<b>50 mg</b>	

Date

Time

Physician's Signature

MD Number

