

(Place Patient Identification Sticker Here)



**Physician Orders ADULT**  
**Order Set: Velcade Dex**

**Diagnosis : Multiple Myeloma**

Height: _____ cm	Weight: _____ kg	Cycle: _____	Of : _____	
Actual BSA: _____ m <sup>2</sup>	Treatment BSA: _____ m <sup>2</sup>	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 type="checkbox"/> Nursing Communication		T;N, Do not exceed a treatment BSA of _____ m <sup>2</sup>		
<b>Medications</b>				
<b>CHEMOTHERAPY</b>				
	<b>Drug (generic) &amp; solution (optional)</b>	<b>Intended Dose</b>	<b>Actual Dose</b>	<b>Route, Infusion, Frequency and total doses</b>
<input checked="" type="checkbox"/>	<b>bortezomib</b>	<b>1.3 mg/m<sup>2</sup></b>		Subcutaneous, Daily on DAYS 1,4,8, and 11
<input checked="" type="checkbox"/>	<b>dexamethasone</b>	<b>40 mg</b>	<b>40 mg</b>	PO, once a week
<b>Acute Emesis Prophylaxis ( may undergo therapeutic interchange)</b>				
<b>NOTE: Administer initial doses at least 30-60 minutes prior to chemotherapy</b>				
<input checked="" type="checkbox"/>	ondansetron	8 mg, Injection, IV Push, qDay, on DAYS 1, 4, 8 and 11		
<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		
<b>Consults/Notifications</b>				
<input type="checkbox"/>	Notify Physician- Once	T;N, Who: _____ , For: if BSA exceeds 2 m <sup>2</sup>		

Date

Time

Physician's Signature

MD Number

