attach patient label here

Methodist Le Bonheur Healthcare

Physician Orders ADULT

Order Set: MEC

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		
Continuous Infusions				
Pre Hydration				
[X]	Normal Saline	1,000 mL, IV, Routine, ____mL/hr		
Medications				
[X]	PrednisoLONE opthalmic 1%	2 drops, Opthalmic Susp, Both eyes, q6h, on DAYS 1-7		
CHEMOTHERAPY				
	Drug (generic) & solution (optional)	**Intended Dose**	**Actual Dose**	**Route, Infusion, Frequency and total doses**
[X]	**mitoxantrone**	**12 mg/m^2**		**IV Piggyback, Infuse over 15 min, q24h on DAYS 1-3**
[X]	**etoposide**	**100 mg/m^2**		**IV Piggyback, Infuse over 90 min, q24h on DAYS 1- 5**
[X]	**cytarabine**	**1000 mg/m^2**		**IV Piggyback, Infuse over 3 hours, q 12 hours on DAYS 1-5**
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 1-5		
[X]	dexamethasone	12 mg, Injection, IV Push, Q Day , on DAYS 1 - 5		
[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**