

Physician Orders ADULT
Order Set: CHOP
Diagnosis : Non- Hodgkin's Lymphoma Chemotherapy

Height: _____ cm		Weight: _____ kg		Cycle: _____ Of : _____	
Actual BSA: _____ m2		Treatment BSA: _____ m2		Day/Wk: _____ Freq: _____	
Allergies:					
<input type="checkbox"/> No known allergies					
<input type="checkbox"/> Medication allergy(s): _____					
<input type="checkbox"/> Latex allergy <input type="checkbox"/> Other: _____					
Patient Care					
<input type="checkbox"/>	Nursing Communication	T;N, Do not exceed a treatment BSA of _____ m2			
<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			
Continuous Infusions					
Pre Hydration					
<input type="checkbox"/>	Normal Saline	1,000 mL, IV, Routine, _____ mL/hr , Start 4 hours prior to chemotherapy and continue for at least 24 hours after chemotherapy is complete			
Medications					
CHEMOTHERAPY					
	Drug (generic) & solution (optional)	Intended Dose	Actual Dose	Route, Infusion, Frequency and total doses	
<input checked="" type="checkbox"/>	cyclophosphamide	750 mg/m²		IV Piggyback, Infuse over 90 min, ONCE on DAY 1	
<input checked="" type="checkbox"/>	DOXOrubicin	50 mg/m²		IVPush, ONCE on DAY 1	
<input checked="" type="checkbox"/>	vinCRISTine	1.4 mg/m²		IVPush, ONCE on DAY 1 MAX DOSE 2 mg	
<input checked="" type="checkbox"/>	predniSONE	100 mg	100 mg	PO, q24h on days 1- 5	
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, Once, DAY 1			
<input checked="" type="checkbox"/>	prochlorperazine	10 mg, Injection, IV Push, q6h, PRN Nausea/Vomiting , Comment : if unable to take PO			
<input checked="" type="checkbox"/>	prochlorperazine	10 mg, Tab, PO, q6h, PRN Nausea/Vomiting			
Consults/Notifications					
<input type="checkbox"/>	Notify Physician- Once	T;N, Who: _____, For: if BSA exceeds 2 m ²			

Date

Time

Physician's Signature

MD Number