Methodist Le Bonheur Healthcare[SM]

CHEMOTHERAPY ORDER FORM

PAGE ______ OF ______

START DATE:	DIAGNOSIS:	VENOUS ACCESS □ Central: ______ □ Peripheral
PROTOCOL / REGIMEN:	CYCLE: OF: Day/ Wk: Freq:	

PT NAME____________________ RM ______
(OR ADDRESSOGRAPH)

PRE-LAB

Obtain the following, prior to chemotherapy:
- □ CBC (includes differential)
- □ CMP or □ BMP
- □ Other: ______________________________

____

Lab results from ____________
WBC ________ ANC ________
Plt ________
SCr________ T/ D Bili _______
CrCl (meas or calc) _____________
Other:

□ Call values to ____________ before administration
□ Pharmacy may order lab pertinent to dosing (on back)
□ Hold therapy for any of the following & notify MD:
WBC < _______ ANC < _______ Plt < _______
SCr > ________ CrCl < _______ T Bili > ______
Other:

M^2

Height (cm):	Weight: (lb) (kg)	Actual BSA (m^2):	Treatment BSA (m^2):	□ Call ________________, if BSA exceeds 2 m^2 □ Do NOT exceed a Treatment BSA of _________ m^2

PRE-MEDS

Hydration/Pre-Med:

□ May hold hydration during chemotherapy infusion

CHEMOTHERAPY / IMMUNOTHERAPY

Drug (generic) & Solution (optional)	Intended Dose /m^2, AUC, or Dose / kg	Actual Dose (mg or Units)	Route & Infusion Duration	Frequency and number of doses
	□ mg/m^2 □ mg/kg □ Unit/m^2 □ Unit/kg □ AUC □ Flat dose	□ See dosage cap	□ IV Push □ CIV over 24 hours □ IV PB over ________ □ SQ □ IM □ Oral □ Unit/m^2 □ Unit/kg □ Other : __________	□ ONCE on _____________ □ Daily on days _____________ □ Q ____ hr for _______ doses, starting on _____________ □ Other : _____________
	□ mg/m^2 □ mg/kg □ Unit/m^2 □ Unit/kg □ AUC □ Flat dose	□ See dosage cap	□ IV Push □ CIV over 24 hours □ IV PB over ________ □ SQ □ IM □ Oral □ Unit/m^2 □ Unit/kg □ Other : __________	□ ONCE on _____________ □ Daily on days _____________ □ Q ____ hr for _______ doses, starting on _____________ □ Other : _____________
	□ mg/m^2 □ mg/kg □ Unit/m^2 □ Unit/kg □ AUC □ Flat dose	□ See dosage cap	□ IV Push □ CIV over 24 hours □ IV PB over ________ □ SQ □ IM □ Oral □ Unit/m^2 □ Unit/kg □ Other : __________	□ ONCE on _____________ □ Daily on days _____________ □ Q ____ hr for _______ doses, starting on _____________ □ Other : _____________
	□ mg/m^2 □ mg/kg □ Unit/m^2 □ Unit/kg □ AUC □ Flat dose	□ See dosage cap	□ IV Push □ CIV over 24 hours □ IV PB over ________ □ SQ □ IM □ Oral □ Unit/m^2 □ Unit/kg □ Other : __________	□ ONCE on _____________ □ Daily on days _____________ □ Q ____ hr for _______ doses, starting on _____________ □ Other : _____________

Additional Orders or Instructions:

ANTI-EMETICS

ACUTE EMESIS PROPHYLAXIS (may undergo therapeutic interchange).
Administer initial QD doses at least 30 - 60 minutes prior to chemotherapy.
- □ Granisetron / Dolasetron / Ondansetron (circle) : ________ mg by PO / IV (circle) on ______________________________
- □ Dexamethasone ________ mg PO / IV (circle) on______________________
- □ Lorazepam ______ mg PO / IV (circle) Q _____ on __________________
- □ Prochlorperazine ______ mg PO / IV (circle) Q _____ on ______________
- □ Other/Breakthrough: ____________________ ________________

DELAYED EMESIS PROPHYLAXIS - Start on _______________
- □ Dexamethasone 8 mg PO BID x2 days, then 4 mg PO BID x2 days
- □ Dexamethasone ______ mg PO Q _______for _____________
- □ Granisetron / Dolasetron / Ondansetron (circle): ________mg PO Q _______ for ______________________
- □ Metoclopramide ______ mg PO Q _______ for ______________
- □ Prochlorperazine ______ mg PO Q ______ for ______________
- □ Other: ____________________ ________________

If other than prescriber, signature, tittle (& initials) of individual providing:

MD Signature : ____________________ Date : ____/____/_____ Time : ____ :_____ am pm

Ht & Wt: ______________________________ (________)

Attending MD Signature (if applicable): ________________________

Dosage calculated/verified by: _______________ (________)

* 0 6 5 *