(Place Patient Identification Sticker Here)

Methodist Le Bonheur Healthcare

Physician Orders ADULT
Order Set: DHAP

Diagnosis : Non- Hodgkin's Lymphoma Chemotherapy

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 , Start 4 hours prior to chemotherapy and continue for at least 24 hours after cisplatin infusion is complete	
[X]	PrednisoLONE 1% ophthalmic suspension	2 drops, both eyes, q6h, on DAYS 2-4	
Medications			
CHEMOTHERAPY			
	Drug (generic) & solution (optional)	**Intended Dose**	**Actual Dose**	**Route, Infusion, Frequency and total doses**
[X]	**CISplatin**	**100 mg/m^2**		**Continuous Infusion, Infuse over 24 hours, Once on DAY 1**
[X]	**cytarabine**	**2000 mg/m^2**		**IV Piggyback, Infuse over 2 hours, q 12hr x 2 doses starting on DAY 2**
[X]	**dexamethasone**	**40 mg**	**40 mg**	**PO, q24h on DAYS 1-4**
Acute Emesis Prophylaxis (may undergo therapeutic interchange)			
NOTE: Administer intial doses at least 30-60 minutes prior to chemotherapy			
[X]	aprepitant	125 mg, Tab, PO, once, on DAY 1	
[X]	aprepitant	80 mg, Tab, PO, qDay, on DAY 2 and 3	
[X]	ondansetron	12 mg, Injection, IV Piggyback, qDay, on DAYS 1-3	
[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	
Delayed Emesis Prophylaxis			
NOTE: Start on Day _____			
[ ]	dexamethasone	8 mg, Tab, PO, bid, for 2 days Comment: Day 1 and 2 of delayed emesis prophylaxis	
[ ]	dexamethasone	4 mg, Tab, PO, bid, for 2 days, Comment: Day 3 and 4 of delayed emesis prophylaxis	
[ ]	dexamethasone	Dose: mg, Tab, PO, Frequency: , Duration:	
[ ]	ondansetron	Dose: mg, Tab, PO, Frequency: , Duration:	
[ ]	metoclopramide	Dose: mg, Tab, PO, Frequency: , Duration:	
[ ]	prochlorperazine	Dose: mg, Tab, PO, Frequency: , Duration:	
Consults/Notifications			
[ ]	Notify Physician- Once	T;N, Who: , For: if BSA exceeds 2 m^2	

Date **Time** **Physician's Signature** **MD Number**