

(Place Patient Identification Sticker Here)



Physician Orders ADULT
Order Set: FOLFOX 4
Diagnosis : colorectal cancer

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, No ice or cold food/beverages for 48 hours after oxaliplatin infusion. After 48 hours may advance as tolerated		
Medications				
Note : Choose all the below orders to be administered prior to oxaliplatin and after completion of oxaliplatin				
<input type="checkbox"/>	calcium gluconate	1 g, Injection, IV Piggyback, once, Comment : Give prior to oxaliplatin on DAY 1 only		
<input type="checkbox"/>	calcium gluconate	1 g, Injection, IV Piggyback, once, Comment : Give after oxaliplatin on DAY 1 only		
<input type="checkbox"/>	magnesium sulfate	1 g, Injection, IV Piggyback, once, Comment : Give prior to oxaliplatin on DAY 1 only		
<input type="checkbox"/>	magnesium sulfate	1 g, Injection, IV Piggyback, once, Comment : Give after oxaliplatin on DAY 1 only		
CHEMOTHERAPY				
	Drug (generic) & solution (optional)	Intended Dose	Actual Dose	Route, Infusion, Frequency and total doses
<input checked="" type="checkbox"/>	oxaliplatin (in D5W)	85 mg/m²		IV Piggyback, Infuse over 2 hours, ONCE on DAY 1; infuse before fluorouracil
<input checked="" type="checkbox"/>	leucovorin(In D5W)	200 mg/m²		IV Piggyback, Infuse over 2 hours, May infuse with oxaliplatin, ONCE on DAYS 1 and 2
<input checked="" type="checkbox"/>	fluorouracil	400 mg/m²		IV Push, over 5 min, ONCE on DAYS 1 and 2
<input checked="" type="checkbox"/>	fluorouracil	600 mg/m² per day		Continuous Infusion, Infuse over 24 hours, Once on DAYS 1 and 2
NOTE: Administer initial doses at least 30-60 minutes prior to chemotherapy				
<input checked="" type="checkbox"/>	ondansetron	12 mg, Injection, IV Piggyback, qDay, DAYS 1- 2		
<input checked="" type="checkbox"/>	dexamethasone	12 mg, Injection, IV Piggyback, qDay, DAYS 1- 2		
<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		



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Delayed Emesis Prophylaxis

NOTE: Start on Day		
<input type="checkbox"/>	dexamethasone	8 mg, Tab, PO, bid, for 2 days Comment: Day 1 and 2 of delayed emesis prophylaxis
<input type="checkbox"/>	dexamethasone	4 mg, Tab, PO, bid, for 2 days, Comment: Day 3 and 4 of delayed emesis prophylaxis
<input type="checkbox"/>	dexamethasone	Dose: _____ mg, Tab, PO, Frequency: _____, Duration: _____
<input type="checkbox"/>	ondansetron	Dose: _____ mg, Tab, PO, Frequency: _____, Duration: _____
<input type="checkbox"/>	metoclopramide	Dose: _____ mg, Tab, PO, Frequency: _____, Duration: _____
<input type="checkbox"/>	prochlorperazine	Dose: _____ mg, Tab, PO, Frequency: _____, Duration: _____
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