

Physician Orders ADULT
Order Set: decitabine
Diagnosis : AML

Height: _____ cm		Weight: _____ kg		Cycle: _____ Of : _____	
Actual BSA: _____ m ²		Treatment BSA: _____ m ²		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 _____ m ²			
<input type="checkbox"/>	Nursing Communication	T;N, May hold hydration during chemotherapy infusion			
Continuous Infusions					
Pre Hydration					
<input type="checkbox"/>	Normal Saline	1,000 mL, IV, Routine, _____ mL/hr			
Medications					
CHEMOTHERAPY					
	Drug (generic) & solution (optional)	Intended Dose	Actual Dose	Route, Infusion, Frequency and total doses	
<input checked="" type="checkbox"/>	decitabine	20 mg/m²		IV Piggyback, Infuse over 60 min, 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	8 mg, Injection, IV Piggyback, qDay, on DAYS 1-5			
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