

(Place Patient Identification Sticker Here)



Physician Orders ADULT

Order Set: Hyper CVAD-even cycles

Diagnosis : ALL

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 checked="" type="checkbox"/>	sterile water + sodium bicarbonate (150 mEq)	1,000 mL, IV, Routine, _____ mL/hr			
Medications					
<input checked="" type="checkbox"/>	PrednisolONE ophthalmic 1%	2 drops, Ophthalmic Susp, Both eyes, q6h, on DAYS 1-5			
CHEMOTHERAPY					
	Drug (generic) & solution (optional)	Intended Dose	Actual Dose	Route, Infusion, Frequency and total doses	
<input checked="" type="checkbox"/>	methotrexate	1000 mg/m²		Continuous Infusion, Infuse over 24 hours, ONCE on DAY 1	
<input checked="" type="checkbox"/>	cytarabine	3000 mg/m²		IV Piggyback, Infuse over 3 hours, q 12 hours x 4 doses, on DAYS 2 and 3, Start at end of methotrexate infusion	
<input checked="" type="checkbox"/>	leucovorin	50 mg	50 mg	IV Piggyback, Infuse over 30 min, q 6 hours x 8 doses, starting 12 hours after completion of methotrexate infusion	
Acute Emesis Prophylaxis (may undergo therapeutic interchange)					
NOTE: Administer initial doses at least 30-60 minutes prior to chemotherapy					
<input checked="" type="checkbox"/>	ondansetron	12 mg, Injection, IV Piggyback, qDay, on DAYS 1-3			
<input checked="" type="checkbox"/>	dexamethasone	12 mg, Injection, IV Push, Q Day , on DAYS 1 - 3			
<input checked="" type="checkbox"/>	prochlorperazine	10 mg, Tab, PO, q6h, PRN Nausea/Vomiting			
<input checked="" type="checkbox"/>	prochlorperazine	10 mg, Injection, IV Push, q6h, PRN Nausea/Vomiting , Comment : if unable to take PO			
Laboratory					
<input type="checkbox"/>	methotrexate Level	T+1; N, Routine, Blood, Comment : On completion of methotrexate infusion			
<input type="checkbox"/>	methotrexate Level	T+2; N, Routine, Blood, qday, Comment : Until level is less than 0.01 mmol/L			
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

51026-CHEMO-Hyper CVAD even cycle Orders-QM0811-030118

