attach patient label here

Methodist Le Bonheur Healthcare

Physician Orders ADULT

Order Set: FOLFIRI

Diagnosis : Metastatic colorectal cancer

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		
Medications				
[X]	atropine	0.25 mg, Injection, IV Push, q 6h, PRN diarrhea or abdominal cramping Comment : DAY 1 only		
NOTE: Start on Day 2				
[X]	loperamide	4 mg, Cap, PO, Once, Comment: after first loose stool		
[X]	loperamide	2 mg, Cap, PO, q 2h, PRN diarrhea , Comment : Start after 4 mg dose given		
CHEMOTHERAPY				
	Drug (generic) & solution (optional)	**Intended Dose**	**Actual Dose**	**Route, Infusion, Frequency and total doses**
[X]	**irinotecan**	**180 mg/m^2**		**IV Piggyback, Infuse over 90 min, ONCE on DAY 1**
[X]	**leucovorin**	**400 mg/m^2**		**IV Piggyback, Infuse over 2 hours, ONCE on DAY 1**
[X]	**fluorouracil**	**400 mg/m^2**		**IV Push, Push over 5 minutes, ONCE on DAY 1**
[X]	**fluorouracil**	**1200 mg/m^2 per day**		**Continuous Infusion, Infuse over 24 hours, Once on DAYS 1 and 2**
NOTE: Administer intial doses at least 30-60 minutes prior to chemotherapy				
[X]	ondansetron	12 mg, Injection, IV Piggyback, qDay, DAYS 1- 2		
[X]	dexamethasone	12 mg, Injection, IV Piggyback, qDay, DAYS 1- 2		
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**