

Diagnosis: _____

Allergies: _____

INSTRUCTIONS

1. All chemotherapy regimens must be ordered on this form.
2. Orders for chemotherapeutic agents must be received in Pharmacy at least 48 hours prior to first dose.

Unit: _____

Section 1: Patient information - Complete all information requested

Regimen/Protocol (attach reference as needed) _____ Course# _____ Cycle # _____
 Start date (Day 1): _____
 Height (cm) _____ Actual Weight (kg) _____ Ideal Weight (kg) _____ Dosing Weight (kg) _____ Dosing BSA (m²) _____

Section 2: Hydration and pre-medications – Include dose, route, frequency, and start day

A. Hydration				Administration Day:
B. Pre-medications	Dose (mg)	Route	Frequency	Administration Day:
		<input type="checkbox"/> IVPB <input type="checkbox"/> Oral <input type="checkbox"/> _____	<input type="checkbox"/> One Time <input type="checkbox"/> Daily x _____ <input type="checkbox"/> _____	
		<input type="checkbox"/> IVPB <input type="checkbox"/> Oral <input type="checkbox"/> _____	<input type="checkbox"/> One Time <input type="checkbox"/> Daily x _____ <input type="checkbox"/> _____	
		<input type="checkbox"/> IVPB <input type="checkbox"/> Oral <input type="checkbox"/> _____	<input type="checkbox"/> One Time <input type="checkbox"/> Daily x _____ <input type="checkbox"/> _____	
C. Hypersensitivity reaction medications	Dose (mg)	Route	Frequency	PRN:
		<input type="checkbox"/> IVPB <input type="checkbox"/> Oral <input type="checkbox"/> _____	<input type="checkbox"/> One Time <input type="checkbox"/> Q _____ Hours <input type="checkbox"/> _____	
		<input type="checkbox"/> IVPB <input type="checkbox"/> Oral <input type="checkbox"/> _____	<input type="checkbox"/> One Time <input type="checkbox"/> Q _____ Hours <input type="checkbox"/> _____	
		<input type="checkbox"/> IVPB <input type="checkbox"/> Oral <input type="checkbox"/> _____	<input type="checkbox"/> One Time <input type="checkbox"/> Q _____ Hours <input type="checkbox"/> _____	

Section 3: Antineoplastic agents - List in sequential order of administration

Drug	Dose per Weight / BSA	Calculated Dose	Route	Frequency	Administration Day:
	_____ mg/m ² _____ mg/kg	_____ mg	<input type="checkbox"/> IVPB <input type="checkbox"/> Oral <input type="checkbox"/> _____	<input type="checkbox"/> One Time <input type="checkbox"/> Daily x _____ <input type="checkbox"/> _____	
	_____ mg/m ² _____ mg/kg	_____ mg	<input type="checkbox"/> IVPB <input type="checkbox"/> Oral <input type="checkbox"/> _____	<input type="checkbox"/> One Time <input type="checkbox"/> Daily x _____ <input type="checkbox"/> _____	
	_____ mg/m ² _____ mg/kg	_____ mg	<input type="checkbox"/> IVPB <input type="checkbox"/> Oral <input type="checkbox"/> _____	<input type="checkbox"/> One Time <input type="checkbox"/> Daily x _____ <input type="checkbox"/> _____	
	_____ mg/m ² _____ mg/kg	_____ mg	<input type="checkbox"/> IVPB <input type="checkbox"/> Oral <input type="checkbox"/> _____	<input type="checkbox"/> One Time <input type="checkbox"/> Daily x _____ <input type="checkbox"/> _____	
	_____ mg/m ² _____ mg/kg	_____ mg	<input type="checkbox"/> IVPB <input type="checkbox"/> Oral <input type="checkbox"/> _____	<input type="checkbox"/> One Time <input type="checkbox"/> Daily x _____ <input type="checkbox"/> _____	

*Note: The volume, diluent, and infusion rate are set by pharmacy unless indicated under "special instructions"
 Carboplatin Only: Target AUC _____ GFR _____ ml/min Dose = Target AUC x (GFR + 25) = _____ mg
 Special instructions and treatment parameters _____

Physician signature _____ Date / Time _____

6066-001 (7/24/17) PATIENT I.D.



VALLEY PRESBYTERIAN HOSPITAL

INPATIENT CHEMOTHERAPY ORDER FORM

