Diagnosis: ______________________________ **Allergies:** ______________________

Unit: ______________________________

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.

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 (m^2) _________

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:
		☐ IVPB ☐ Oral ☐ _________	☐ One Time ☐ Daily x ________________ ☐ ____________________	
		☐ IVPB ☐ Oral ☐ _________	☐ One Time ☐ Daily x ________________ ☐ ____________________	
		☐ IVPB ☐ Oral ☐ _________	☐ One Time ☐ Daily x ________________ ☐ ____________________	

C. Hypersensitivity reaction medications	Dose (mg)	Route	Frequency	PRN:
		☐ IVPB ☐ Oral ☐ _________	☐ One Time ☐ Q _______________ Hours ☐ ____________________	
		☐ IVPB ☐ Oral ☐ _________	☐ One Time ☐ Q _______________ Hours ☐ ____________________	
		☐ IVPB ☐ Oral ☐ _________	☐ One Time ☐ Q _______________ Hours ☐ ____________________	

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	☐ IVPB ☐ Oral ☐ _________	☐ One Time ☐ Daily x ________________ ☐ ____________________	
	________ mg/m^2 ________ mg/kg	________ mg	☐ IVPB ☐ Oral ☐ _________	☐ One Time ☐ Daily x ________________ ☐ ____________________	
	________ mg/m^2 ________ mg/kg	________ mg	☐ IVPB ☐ Oral ☐ _________	☐ One Time ☐ Daily x ________________ ☐ ____________________	
	________ mg/m^2 ________ mg/kg	________ mg	☐ IVPB ☐ Oral ☐ _________	☐ One Time ☐ Daily x ________________ ☐ ____________________	
	________ mg/m^2 ________ mg/kg	________ mg	☐ IVPB ☐ Oral ☐ _________	☐ One Time ☐ Daily x ________________ ☐ ____________________	

**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 ____

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____

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Physician signature____ Date / Time ______________________

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

VALLEY PRESBYTERIAN HOSPITAL

INPATIENT CHEMOTHERAPY ORDER FORM