CHEMOTHERAPY ORDER FORM

Nurse to complete

Date: ____________

Time: ____________

Previous Chemo Tx: ☐ **YES** ☐ **NO** *If YES, disregard below lab results

Patient Data Height: __________ Actual Weight: __________ kg ***or*** __________ lb BSA: __________

Diagnosis: ____________________

Allergies: ____________________

Lab Results (date drawn:____________)

SrCr: __________ Tbili: __________ WBC: __________ Platelets: __________

Hgb/Hct: __________ ANC: __________ Other: __________

Medications:

Date/ Day	DRUG	Dose (mg/kg or mg/m²)	Calculated Dose (in mg)	Route	Frequency	Special Instructions

**Note: The volume, diluent, and infusion rate are set by pharmacy unless indicated under "special instructions"*

Concurrent Therapies/Ancillary Meds

Antiemetics:

☐ No antiemetic ☐ Phenergan: __________

☐ Zofran: __________ ☐ Ativan: __________

☐ Decadron: __________

Ancillary Meds:

☐ No Meds ☐ Neupogen: __________

☐ Procrit: __________ ☐ Neulasta: __________

☐ Other: ☐ __________ ☐ __________

Other Orders or Special Instructions: ____________________

____

____

____

MD SIGNATURE: ____________________

For Rx Use Only: *Prep by:* __________ *Reviewed by:* __________ *Time Received:* __________ *Time Complete:* __________

The Center of Attention

Chemotherapy Order Form

O:PH0001 (Rev. 07/21/05)