United Regional Health Care System

Patient Label

Chemotherapy Order Form

Appointment: Date __________ Time __________
Allergies ____________________________________
Diagnosis ____________________________________
Protocol/Regimen _____________ Cycle # __________
Actual Weight: ______ lb/kg Height______ in/cm BSA______ (m^2) SCr _______ Plt _______ WBC ______

Hydration: ___________________ ☐Before ☐During ☐After
Primary fluid: KVO NS 250 mL or D5W 250 mL as appropriate per medication

Medication	Dose	Route	Frequency	Medication	Dose	Route	Frequency
Acetaminophen				diphenhydramine			
Dexamethasone				Granisetron (Kytril)			
Lorazepam (Ativan)				Promethazine			
Dolasetron (Anzemet)				Atropine			
Famotidine (Pepcid)				Metoclopramide			
Ondansetron (Zofran)				Cimetidine (Tagament)			

Chemotherapy Medications:

Drug (Generic)	Calculated Dose	Dose	Solution Check box to use Standard	Rate/Frequency	#Days	Lifetime dose
	_____mg/m^2 ______ AUC					
	_____mg/m^2 ______AUC					
	_____mg/m^2 ______AUC					
	_____mg/m^2 ______AUC					
	_____mg/m^2 ______AUC					

Additional Orders or Special instructions: *Standard diluent/vehicle and rate to be calculated by pharmacy if not given

Medication	Dose, Route, and Frequency	Medication	Dose, Route, Frequency
Darbepoetin (Aranesp)		Epoetin (Procrit)	
Pegfilgrastim (Neulasta)		Filgrastim (Neupogen)	

____
____
____
____

Physician Signature: ______________________ Date: ___________ Time: ________ 1st R.Ph ___________

Physician Signature: ______________________ Date: ___________ Time: ________ 2nd R.Ph ___________
Revised: July 2005

ONCO 0012