

Patient Label

Chemotherapy Order Form

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Date: _____ Time: _____

Admit Inpatient or Outpatient Admit to private room

Allergies:

Diagnosis:

Pre-medication:

KVO NS 250 ml or D5W 250 ml as appropriate per medication

- Acetaminophen (Tylenol) 650 mg po Q 4 hours as needed for fever
Diphenhydramine (Benadryl) mg IV Q 4 hours as needed for itching
Dexamethasone (Decadron) mg IV Q for N/V x days
Dexamethasone (Decadron) mg PO Q for N/V x days
Dolasetron (Anzemet) 100 mg IV Q 24 hours as needed for N/V x days
Granisetron (Kytril) 1 mg IV Q 24 hours as needed for N/V x days
Granisetron (Kytril) 1 mg PO Q 24 hours as needed for N/V x days
Ondansetron (Zofran) IV Q 24 hours as needed for N/V x days
Ondansetron (Zofran) PO Q 24 hours as needed for N/V x days
Famotidine (Pepcid) mg IV
Metoclopramide (Reglan) mg IV
Promethazine (Phenergan) mg IV Q 4 hours as needed for N/V x days
Cimetidine (Tagamet) mg
Atropine mg

Other pre-medication orders:

Additional orders:

- Darbepoetin (Aranesp) mcg SQ (Outpatient only)
Epoetin (Procrit) Units
Pegfilgrastim (Neulasta) 6 mg (Outpatient only)
Filgrastim (Neupogen) mcg

Additional orders:

Physician Signature: _____ Date: _____ Time: _____

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Appointment: Date _____ Time _____
 Allergies _____
 Diagnosis _____
 Protocol/Regimen _____ Cycle # _____
 Actual Weight: _____ lb/kg Height _____ in/cm BSA _____ (m²) SCr _____ Plt _____ WBC _____

Cytotoxic Medications:

Drug (generic)	Calculated Dose	Patient 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					
	____ mg/m ² ____ AUC					

*Standard diluent/vehicle and rate to be calculated by pharmacy if not given
 **Cytotoxic agent requires 24 hour notice (Policy 7071.0065.001)

Physician Signature: _____ Date: _____ Time: _____ 1st R.Ph _____

Physician Signature: _____ Date: _____ Time: _____ 2nd R.Ph _____

Physician Signature: _____ Date: _____ Time: _____

Revised: July 2005