Date(s) chemotherapy to be given on: ___/___/____ Approx.Time Due: _____

1. PATIENT INFORMATION:

Diagnosis: _____

Chemotherapy Regimen_____

*If non-standard regimen please attach reference or copy of protocol

Ht._____ Wt._____ lbs/kg (circle one) BSA_____

Cycle #_____ Date of last chemo: _____ If mid-cycle day #_____ (i.e. for Infusion Center)

2. LABORATORY VALUES: (or attach copy of most recent labs)

Date:_____ WBC_____ ANC _____ Hgb _____ HCT _____ Platelets _____

Creatinine _____ Total Bilirubin _____ AST/ALT_____

Dosage adjustments/reasons: _____

3. PRE-MEDICATIONS:

☐ Acetaminophen ☐ 325mg ☐ 500mg ☐ 650mg ☐ 1000mg PO Day #_____

☐ Dexamethasone ☐ 10mg ☐ 20mg ☐ IV or ☐ PO Day #_____

☐ Diphenhydramine ☐ 25mg ☐ 50mg ☐ IV or ☐ PO Day #_____

☐ Cimetidine 300mg IV Day #_____

4. HYDRATION:

5. ANTI-EMETICS: (See guidelines on back page)

Scheduled Antiemetics - Administer 30-60 minutes prior to chemotherapy each day.

☐ Ondansetron 8 mg IV DAYS:_____

☐ Dexamethasone ☐ 4 mg ☐ 8 mg ☐ 10mg ☐ 20mg ☐ PO ☐ IV DAYS:_____

☐ Lorazepam ☐ 0.5 mg ☐ 1 mg ☐ PO ☐ IV DAYS:_____

☐ Prochlorperazine ☐ 10 mg ☐ PO ☐ IV DAYS:_____

Breakthrough Antiemetics

☐ Promethazine 25 mg PO or 6.25 - 12.5mg IV q 4-6 hours PRN ☐ Haloperidol 1 - 2 mg PO/IV Q 6 hours PRN

☐ Lorazepam 0.5 - 1 mg PO/IV Q 4 - 6 hours PRN ☐ Metoclopramide 10-20 mg PO/IV Q 6 hours PRN

☐ Prochlorperazine 10 mg PO/IV Q 6-8 hours PRN

Delayed Nausea and Vomiting

☐ Dexamethasone 4-8mg PO bid x 6 doses

☐ Metoclopramide 30 - 40 mg PO q 4-6 hours PRN

☐ Diphenhydramine 25-50 mg PO q 6 hours (to prevent extra-pyramidal side effects)

☐ Prochlorperazine 10 mg PO/IV q 6-8 hours PRN

☐ Ondansetron 8 mg PO BID x 6 doses

6. CHEMOTHERAPY:

Drug:_____ **Dose/m2**_____ or AUC_____ Total Dose:_____ Days:_____

Route: ☐ PO ☐ IV ☐ IVP ☐ IT

Volume:_____ml in ☐ NS ☐ D5W ☐ **Per Pharmacy**

Administer over _____ (specify time period)

Other Instructions : _____

Patient Zebra Label

Drug:______________________________ **Dose/m2**___________ or AUC__________ Total Dose:_________ Days:_________
Route: ☐ PO ☐ IV ☐ IVP ☐ IT
Volume:_________ml in ☐ NS ☐ D5W ☐ **Per Pharmacy**

Administer over _______________ (specify time period)

Other Instructions : ____

Drug:______________________________ **Dose/m2**___________ or AUC__________ Total Dose:_________ Days:_________
Route: ☐ PO ☐ IV ☐ IVP ☐ IT
Volume:_________ml in ☐ NS ☐ D5W ☐ **Per Pharmacy**

Administer over _______________ (specify time period)

Other Instructions : ____

Drug:______________________________ **Dose/m2**___________ or AUC__________ Total Dose:_________ Days:_________
Route: ☐ PO ☐ IV ☐ IVP ☐ IT
Volume:_________ml in ☐ NS ☐ D5W ☐ **Per Pharmacy**

Administer over _______________ (specify time period)

Other Instructions : ____

7. SUPPORTIVE THERAPIES:

☐ Neupogen [ ] 300 mcg [ ] 480 mcg [ ] Other **to start Day #** _____
☐ Procrit / Epogen [ ] 40,000 units [ ] 60,000 units [ ] Other **to start Day #** _____

8. OTHER ORDERS AND INSTRUCTIONS: (labs, I/O, urinalysis, etc.....)

[ ] Potential side effects of above regimen discussed with patient and/or family

Physician Signature: ____________________________ Date: __________ Time: ___________

Patient Zebra Label