Jan. 9. 2020 11:42AM No. 2656 P. 1

Caminati, Jane.
MRN 979164 DOB 3/30/53

Patient Label

ORANGE REGIONAL MEDICAL CENTER

CHEMOTHERAPY ORDERS

TO BE COMPLETED BY PHYSICIAN: Patient Name: DOB:

Date Written: 1/9/2020 **Date of Administration:** 2/20/2020

Diagnosis: **TNM Stage:**

Protocol / Regimen: **Cycle:** of: **Day:**

Allergies: ☒ NKDA

Venous Access: ☐ Peripheral ☐ Central

Height ___ft ___in **Weight** ___ kg ☐ Actual ☐ Ideal ☐ Adjusted ☐ Dosing **Body Surface Area (m^2)** **Emetic Level** ☐ Minimal ☐ Moderate ☐ High

Lab Orders: ☐ CBC/DIFF ☐ BMP ☐ Magnesium ☐ UA

Hold Parameters:
ANC less than: **WBC less than:** **PLT less than:** **Hgb/Hct less than:** **SCr greater than:**

Non-chemotherapy orders:	RPh Initials / Nurse initials	
IV Fluids: ◯ Sodium Chloride 0.9% to KVO (20 mL/hr) ◯ Dextrose 5% to KVO (20 mL/hr)		
Premedicate:		
Tylenol 650mg PO x1		
Benadryl 50mg IVP x1		
Famotidine 20mg IVP x1		
Methylprednisolone 80mg IVP x1		

Solution, volume and infusion rate are per manufacturer/hospital guidelines unless otherwise specified. Chemotherapeutic agents will be rounded down to nearest vial size if within 5% of calculated dose. Biological agents will be rounded down to the nearest vial size if within 10% of calculated dose. Please administer chemotherapy in sequence listed below.

Chemotherapy	Dose per Unit (m^2, kg, AUC)	Dose Reduction* (mg/m^2, mg/kg, AUC)	Calculated Dose	Dose Dispensed *(Rounding to be completed by RPh)*	Route	Infusion Rate	RPh / Nurse initials
Rituximab			1000mg		IV		
			day 1 and day 15				

***If using a dose reduction, please provide rationale:** ___

MD Name (Print): Bella Fradlis **MD Signature** ___ **Date/Time** ___

RN Name (Print) ___ **RN Signature** ___ **Date/Time** ___

RPh Name (Print) ___ **RPh Signature** ___ **Date/Time** ___