

2019-12-11 16:08

Steeves, William D.

Sex: M DOB: 2/20/1954 65 y.o.

MRN: 889506 DOS: 1/21/20

Acct: 5001529265

CSN: 12878185



CHEMOTHERAPY ORDERS

William Steeves
MR 889506

Patient Label

TO BE COMPLETED BY PHYSICIAN:		Patient Name:		DOR:			
Date Written: 12/4/19		Date of Administration: 1/21/20		1/21/20			
Diagnosis: autoimmune ataxia		TNM Stage: NA		Allergies: MND			
Protocol/Regimen: rituximab 1,000 mg IV x 2 doses, 2 weeks apart with premedications as below		Cycle of Day 1					
Venous Access: <input checked="" type="checkbox"/> Peripheral <input type="checkbox"/> Central							
Height ft in 170 cm	Weight kg 80 kg	<input checked="" type="checkbox"/> Actual <input type="checkbox"/> Ideal <input type="checkbox"/> Adjusted <input type="checkbox"/> Dosing	Body Surface Area (m ²)	Enzymic Level <input checked="" type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> High			
Lab Orders: <input type="checkbox"/> CBC/DIFF <input type="checkbox"/> BMP <input type="checkbox"/> Magnesium <input type="checkbox"/> 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			
<input type="checkbox"/> IV Fluids: NS @ KVO (20 mL/hr)							
acetaminophen 650 mg PO x 1 dose 30 min prior							
diphenhydramine 50 mg IV x 1 dose 30 min prior							
methylprednisolone 1,000 mg in DSW 100 mL intrve over 30 minutes, 60 minutes prior							
1/21/2020 1214 T.O. Dr. Oxtley / A. Monella							
Charge Benadryl to 25mg po per pt's request / history							
Solution, volume and infusion rate are per manufacturer/hospital guidelines unless otherwise specified. Chemotherapy 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			1,000 mg		IV		

*If using a dose reduction, please provide rationale:

MD Name (Print) Rebecca Farber MD Signature: [Signature] Date/Time 12/4/19

RN Name (Print) RN Signature: [Signature] Date/Time

RPh Name (Print) RPh Signature: [Signature] Date/Time


☐ FAXED ☐ EMAILED

Pharmacy Order Z-1/Pharmacy/11-12

BY DATE

12/16/19

12/12/19 N=2.0