NYMC | Maria Fareri Children's Hospital
Boston Children's Health Physicians
Until every child is well

PEDIATRIC GASTROENTEROLOGY & HEPATOBILIARY DISEASES

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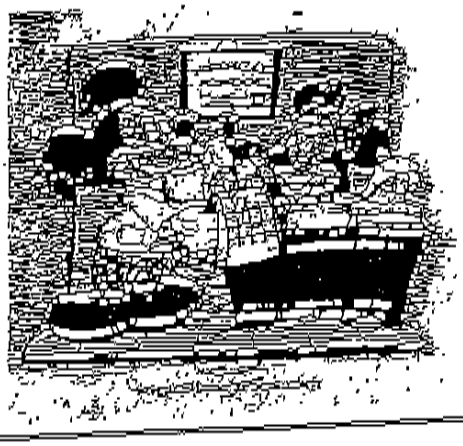

FACSIMILE TRANSMITTAL SHEET

TO: INFUSION CENTER
FROM: MARY
COMPANY: O.R
DATE: 2/4/20
FAX NUMBER: 845-333-9400 ~~845-333-1148~~
TOTAL NO. OF PAGES INCLUDING COVER: 3

ENT/V.I.O
BRIANNA GUZMAN
12/2/06

Brianna Guzman
2 Bliss Terr.
Monroe, NY 10950
Patient Label

ORANGE REGIONAL MEDICAL CENTER

CHEMOTHERAPY ORDERS

TO BE COMPLETED BY PHYSICIAN: Berezin Patient Name: B. Guzman DOB: 12/2/06

Date Written: 2/4/20 Date of Administration: 2/14/20 @ 8A.M

Diagnosis: R50.819 TNM Stage: Allergies: ☐ NKDA

Protocol / Regimen – ENT/VIO Cycle of Day

Venous Access: ☐ Peripheral ☐ Central

Height	Weight	Body Surface Area (m^2)	Emetic Level
5 ft 1 in	kg ☐ Actual ☐ Ideal ☐ Adjusted ☐ Dosing		☐ 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: NS @ KVO (20 mL/hr)		

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	
ENT/VIO			300mg		IV			

*If using a dose reduction, please provide rationale:

MD Name (Print) Stuart Berezin MD Signature Stuart Berezin Date/Time 2/5/20

RN Name (Print) _____ RN Signature _____ Date/Time _____

RPh Name (Print) _____ RPh Signature _____ Date/Time _____

ORANGE REGIONAL MEDICAL CENTER

FAX TRANSMISSION

Date 2/5/20	Time: 1:22 pM	From: Kacy
Receiver's Name: Infusion Inbound Phone Front Desk :845-333-1150 Stacy phone : 845-333-1905 Inbound Fax : 845-333-9400		Department: Phone: 914-367-0019 Fax : 914-367-0002

Number of pages, including this coversheet:
Information Transmitted:

Appointment Date Needed: 2/14/20 @ 8 AM

Name of Patient : BRIANNA GUZMAN

DOB: 12/2/06

MRN # : _____ (If Applicable)

Diagnosis written on Order: K50.819

Authorization Number : _____

Thank you