ORANGE REGIONAL MEDICAL CENTER

CHEMOTHERAPY ORDERS

TO BE COMPLETED BY PHYSICIAN:

Patient Label

Date Written: 1/6/2020 Patient Name: Reyes, Gloria DOB: 9/23/51

Diagnosis: Date of Administration:

Protocol / Regimen: Kadcyla-3 21 days X 14 cycles

TNM Stage:

Cycle: 1 of 14 Day:

Allergies: ☐ NKDA Bactrim Latex

Venous Access: ☐ Peripheral ☐ Central

Height: ft 62 in

Weight: 179 lbs / 81 kg ☐ Actual ☐ Ideal ☐ Adjusted ☐ Dosing

Body Surface Area (m^2): 1.83

Emetic Level: ☐ Minimal ☐ Moderate ☐ High

Lab Orders: ☐ CBC/Diff ☒ BMP ☒ Magnesium ☐ UA every cycle

Hold Parameters:

ANC less than: 1000 WBC less than: PLT less than: 75 K Hgb/Hct less than: SCr greater than: 1.4

Non-chemotherapy orders:

IV Fluids: ◯ Sodium Chloride 0.9% to KVO (20 mL/hr) ◯ Dextrose 5% to KVO (20 mL/hr)

RPh initials / Nurse initials

Dexamethasone 10mg IV

Zofran 16mg IV

*Ensure echo done within 3 months of administration of treatment

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	
Kadcyla	3.6mg/kg IV		291mg					

*If using a dose reduction, please provide rationale:

MD Name (Print): Angela Mauceri MD Signature: Date/Time: 1/7/2020

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

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

Physician Orders/Blank/Chemotherapy Orders-2-1/Pharmacy/11-12

Fax to pharmacy at 338-7124

ORANGE REGIONAL MEDICAL CENTER

PATIENT LABEL

CHEMOTHERAPY INFORMED CONSENT

I hereby authorize Dr. Marcelina D and or associates or assistants of his/her choice, to administer to me the following chemotherapy consisting of the following drugs.

1. Xadagla
2.
3.
4.
5.
6.

I have been fully informed of my diagnosis, nature and purpose of the chemotherapy infusion. The potential benefits and drawbacks including the impact on daily activities related to recuperation have been discussed. The complications, likelihood of success, discomforts and possible risks that may arise have been addressed. The alternatives, including possible results of non treatment have been reviewed with me. I acknowledge that no guarantees or assurances have been given to me about the chemotherapy infusion. I have been given the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

I understand that during the course of this chemotherapy, unforeseen conditions may arise which could require the planned chemotherapy to be altered. All alterations of the proposed plan will be discussed with me by my physician.

I understand that the medications prescribed by my physician can have short term and long term side effects. My physician has educated me about the following side effects that I might experience because of my chemotherapy.

- [x] Nausea / Vomiting
- [x] Anemia / Low Red Blood Cells
- [x] Risk of Infection
- [x] Poor Appetite
- [x] Rash
- [x] Numbness/tingling
- [x] Hair Loss/thinning
- [x] Fatigue
- [x] Mouth Sores
- [x] Diarrhea/Constipation
- [x] Bleeding/low platelet counts
- [x] Other

I also understand that I may stop treatment at any time.

X Patient/Relative Signature: George J Keyes Date: 1/6/2020

Relationship, if not patient: _____ Date: _____

Physician Signature: _____ Date: 1/6/2020

Witness to Patient Signature: _____ Date: 1-6-2020

Form/TCCC/Chemotherapy Informed Consent/EE.em/6/10