

ORANGE
REGIONAL
MEDICAL CENTER

CHEMOTHERAPY ORDERS

TO BE COMPLETED BY PHYSICIAN:

Patient Label

Date Written:

Patient Name:

DOB:

Diagnosis:

Date of Administration:

Protocol / Regimen:

TNM Stage:

Allergies: ☒ NKDA

Gemzar 800 mg/m² weekly
3/4 weeks

Cycle: 1 of 3

Day:

Venous Access: ☐ Peripheral ☐ Central

Height

Weight

☐ Actual☐ Ideal☐ Adjusted☐ DosingBody Surface
Area (m²)

Emetic Level

☐ Minimal☐ Moderate☐ High

Lab Orders:

☒ CBC/DIFF☒ BMP☒ Magnesium☐ UA

Hold Parameters:

☒

ANC less than: 1.5

WBC less than: 2.0

PLT less than: 100

Hgb/Hct less than: 8.0

SCr greater than: 1.0

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 10 mg

Zofran 16 mg

Depo 20 mg

Benadryl 25 mg

IV pre chemo

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
Gemzar	800 mg/m ²		1700		IV	1hr	
	weekly 3/4 weeks						
	(Time out) - 4 weeks						

*If using a dose reduction, please provide rationale:

MD Name (Print):

FAUZIA PARAZI

MD Signature:

Fauzia Parazi

Date/Time:

10-18-19

RN Name (Print):

RN Signature:

Date/Time:

RPh Name (Print):

RPh Signature:

Date/Time:

Physician Orders/Sign/Chemotherapy Orders-Z-1/Pharmacy/1-12

Fax to pharmacy at 353-1124