ORANGE REGIONAL MEDICAL CENTER

CHEMOTHERAPY ORDERS

Sexton, Thomas
11/25/41
Patient Label

TO BE COMPLETED BY PHYSICIAN:	Patient Name:	DOB:
Date Written: 2/17/20	Date of Administration:	
Diagnosis: Met Bladder Ca	TNM Stage: 4	Allergies: ☒ NKDA
Protocol / Regimen – Enfortumab Vedotin	Cycle 1 of 6 Day	
Venous Access: ○ Peripheral ○ Central		

Height	Weight		Body Surface Area (m^2)	Emetic Level
6 ft 0 in	214 lb 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
Enfortumab Vedotin	1.25mg/kg		122mg		IV	per protocol	

*If using a dose reduction, please provide rationale:

MD Name (Print) Manuel Ponce MD Signature [signature] Date/Time 2/17/20 / 1Pm

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

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

Crystal Run Healthcare Physicians LLP

155 Crystal Run Road
Middletown, NY 10941-4028
USA
(845) 703-6999

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
Sexton, Thomas		429899	###-##-5686	11/25/1941	English	M

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY
122 Mohawk Street	Port Jervis, NY 12771	Whalen AGACNP-BC, Allison		Not Hispanic or ...

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE
(845) 856-1218		ifsexton45@gmail.com	Daboul Jr MD, Richard J		Declined to spec...

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE
Married	☐ Full-Time ☐ Part-Time	N	N			(845) 856-1218

SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-time ☐ Part-time				

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#
Medicare Part B		6F29CP8XW18
NAME OF INSURED		GROUP#
Sexton, Thomas		
ADDRESS OF INSURANCE COMPANY		COPAY AMT
PO Box 100		$0.00
CITY, STATE ZIP	PHONE	DEDUCTIBLE
Yorktown Heights, NY 10598-0100	(877) 869-6504	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE / EXPIRATION DATE
SELF		

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#
AARP		07623584011
NAME OF INSURED	SSN# / BIRTHDATE / GROUP#	
Sexton, Thomas		
ADDRESS OF INSURANCE COMPANY		COPAY AMT
PO Box 740819		
CITY, STATE ZIP	PHONE	DEDUCTIBLE
Atlanta, GA 30374-0819	(800) 227-7789	$0.00
RELATIONSHIP TO PATIENT		EFFECTIVE DATE / EXPIRATION DATE
SELF		

*All returned checks are subject to a $25.00 check fee.

I authorize the release of any medical or other information necessary to process claims. I also authorize government benefits to the provider who accepts assignment and authorize payment to the physician/supplier for services provided. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____