

Insert Protocol # and title in page header.

Date of order:	Time of order:	Day 1 of this order:	Patient diagnosis:
Regimen Name:		Cycle #	[] Central Line [] Peripheral Line
Actual Weight: kg	Ideal Weight: kg	Adjusted Weight: kg	Height: cm Body Surface Area: m ²

CHEMOTHERAPY ORDERS: For each drug ordered below, fill in all boxes on the corresponding line or indicate n/a if not applicable.

Chemotherapy Drug	Rec. Dose	BSA / kg	Dose to be given	ROUTE	RATE	FREQUENCY OR DAY #	# OF DOSES

Specify if drug is "from IDS supply".

Specify which arm a patient is randomized to receive.

Note if there are other parameters such as BP or weight.

Include contact information.

PARAMETER(s)	INSTRUCTIONS (Check all that apply)	
	Call Case Mgr/Provider	HOLD
For absolute neutrophil count less than:	[]	[]
For platelets less than:	[]	[]
For Mucositis Grade 3 or 4: Per NCI Guidelines)	[]	[]
For serum creatinine greater than:	[]	[]
Other:	[]	[]
Other:	[]	[]
Prescriber Signature (MD/PA-C/ARNP):	Attending MD Signature (required prior to order submission IF prescriber is not an attending level MD);	
2 nd Attending MD Signature (required for non-standard dose when no resource document is available)	Pharmacist Review Signature (required prior to forwarding to Pharmacy for verification & dispensing)	
Two RNs must verify dose of chemotherapy prior to administration of initial dose	Two RPh's must verify the dose of chemotherapy prior to dispensing initial dose	
1.	1.	
2.	2.	

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DATE OF ORDER: _____ TIME OF ORDER: _____

SUPPORTIVE CARE/OTHER THERAPIES RELATED TO CHEMOTHERAPY						
Check Box	Drug	Dose	Route	Frequency	# of Doses	Notes
Y						
Y						
Y						
Y						
Y						
Y						
Y						
Y						
Y						
Y						
Y						
Y						
Y						
Prescriber Signature (MD/PA-C/ARNP):						

Specify if drug is from IDS supply.

Insert Protocol # and title in page header.

DATE:

Appt Time

<i>Service</i>		<i>Attn/Fellow</i>		<i>NCM</i>																	
APPT	RET	Access	Site	Infusion Appt	Radiology test																
Day	Attnng/ Fellow	£ Port	£ SCCA	(Duration of Appt or name of agent)	Medical Necessity required (TC to add accession number)																
Week	Fellow	£ Hick/PICC	£ UWMC																		
Month	(initials)	£ Peripheral																			
Diagnosis:				ICD-9:																	
Scheduling Comments:			Specific Radiology Questions you would like addressed:																		
<div style="border: 1px solid black; background-color: yellow; padding: 5px; display: inline-block;"> Include study staff contact information. </div>																					
			<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Allergies</td> <td style="width: 15%;">NO</td> <td style="width: 15%;">YES</td> <td style="width: 15%;"></td> </tr> <tr> <td>Pt. Pregnant</td> <td>NO</td> <td>YES</td> <td></td> </tr> <tr> <td>Creatinine > 1.2</td> <td>NO</td> <td>YES</td> <td></td> </tr> <tr> <td>Diabetic</td> <td>NO</td> <td>YES</td> <td></td> </tr> </table>			Allergies	NO	YES		Pt. Pregnant	NO	YES		Creatinine > 1.2	NO	YES		Diabetic	NO	YES	
Allergies	NO	YES																			
Pt. Pregnant	NO	YES																			
Creatinine > 1.2	NO	YES																			
Diabetic	NO	YES																			
			£ ORDER CREATININE (IF NOT OBTAINED IN PAST 2 months)																		
ADMISSION Unit Request _____		Date	Time	Length of Stay																	
Chemo Drugs (to be given inpatient)																					
PHYSICIAN SIGNATURE: (REQUIRED)				Attn:																	

Consortium # 6107: Phase II/III Double Blind Randomized Trial of AZD2171 Versus Placebo in Patients Receiving Paclitaxel/Carboplatin Chemotherapy for the Treatment of Advanced or Metastatic Non-Small Cell Lung Cancer.

Date of order:	Time of order:	Day 1 of this order:	Patient diagnosis: NSCLC	
Regimen Name: Carboplatin and Paclitaxel		Cycle #	<input type="checkbox"/> Central Line	<input type="checkbox"/> Peripheral Line
Actual Weight: kg	Ideal Weight: kg	Adjusted Weight: kg	Height: cm	Body Surface Area: m ²

CHEMOTHERAPY ORDERS: For each drug ordered below, fill in all boxes on the corresponding line or indicate n/a if not applicable.

Chemotherapy Drug	Rec. Dose	BSA / kg	Dose to be given	ROUTE	RATE	FREQUENCY OR DAY #	# OF DOSES
Paclitaxel	200 mg/m ²			IV	Over 3 hours	Day 1	1
Carboplatin <i>SCr=</i>	AUC=6			IV	Over 30 minutes	Day 1	1

Please give Paclitaxel first

PARAMETER(s)	INSTRUCTIONS (Check all that apply)	
	Call Case Mgr/Provider	HOLD
For absolute neutrophil count less than:	<input type="checkbox"/>	<input type="checkbox"/>
For platelets less than:	<input type="checkbox"/>	<input type="checkbox"/>
For Mucositis Grade 3 or 4: (see criteria on reverse side of form)	<input type="checkbox"/>	<input type="checkbox"/>
For serum creatinine greater than:	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

Prescriber Signature (MD/PA-C/ARNP):	Attending MD Signature (required <u>prior</u> to order submission IF prescriber is not an attending level MD);
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Two RNs must verify dose of chemotherapy prior to administration of initial dose	Two RPh's must verify the dose of chemotherapy prior to dispensing initial dose
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WHITE-CHART
YELLOW-PHARMACY
PINK-NURSING

