

Patient Name: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Nursing Care:** (Check box/ fill in to activate)

- Daily Weight
- I/ O
- Oral Care: NS mouth rinse every 4 hours and PRN
- Vitals every 4 hours       Vitals every shift
- Guaiac stools
- Call physician if temp greater than \_\_\_\_\_
- Call physician if patient neutropenic and temp greater than 38° C

**Activity:** (Check box to activate)

- Up ad lib       Strict bedrest       Up w/ assist
- Ambulate in hallway       Up to chair for meals (TID)
- Elevate leg (s)

**Diet:** (Check box/ fill in to activate)

- Regular       NPO       Clear liquids       Full liquids       Comfort foods       2 g Sodium
- ADA: \_\_\_\_\_  Dysphagia pureed/ nectar thick liquids
- Advance diet as tolerated to: \_\_\_\_\_
- Other: \_\_\_\_\_

**Lab/ Diagnostics:** (Check box/ fill in to activate)

- Labs not needed, done within past 48 hrs. Proceed with chemotherapy
- Wait for result(s)/ parameters \_\_\_\_\_ before initiating chemo
- CBC       CBC w/ diff (CD)       CMP       BMP
- Call MD if: HCT less than \_\_\_\_\_  
Platelets less than \_\_\_\_\_  
WBC less than \_\_\_\_\_
- Blood culture X 2 if \_\_\_\_\_

Other: \_\_\_\_\_

**IV Fluids:** (Fill in to activate)

PRE-chemotherapy hydration orders:

IV Fluid: \_\_\_\_\_

Maintenance and POST-chemotherapy hydration orders:

IV Fluid: \_\_\_\_\_

\_\_\_\_\_  
Sign      Date      Time

**Medication Therapy:** (Check box/ fill in to activate)

<b>ROUTINE MEDS</b>	<input type="checkbox"/> Dalteparin (Fragmin) 5000 international units SubQ every 24 hours (prophylaxis) <input type="checkbox"/> Heparin 5000 units SubQ every 8 hours (prophylaxis) <input type="checkbox"/> Enoxaparin (Lovenox) 40 mg SubQ every 24 hours (prophylaxis) <input type="checkbox"/> Enoxaparin (Lovenox) 1 mg/ kg SubQ every 12 hours (full dose) <input type="checkbox"/> Warfarin (Coumadin) per Pharmacy. INR Goal is: _____ <input type="checkbox"/> Intermittent pneumatic compression (SCDs)	VTE Treatment/ Prophylaxis
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<b>PRE-CHEMO MEDICATIONS</b>	<input type="checkbox"/> Diphenhydramine (Benadryl) _____ mg IV prior to initial chemotherapy, then _____ <input type="checkbox"/> Famotidine (Pepcid) 20 mg IV prior to initial chemotherapy, then _____ <input type="checkbox"/> Acetaminophen (Tylenol) _____ mg PO prior to initial chemotherapy, then _____	Pre-medication for Chemotherapy (Give ½ hour before chemotherapy)
<b>PRE-CHEMO MEDICATIONS</b>	<input type="checkbox"/> Ondansetron (Zofran) _____ mg IV 30 minutes prior to chemotherapy, then _____ <input type="checkbox"/> Dexamethasone (Decadron) _____ mg PO/ IV prior to chemotherapy, then _____ <input type="checkbox"/> Aprepitant (Emend) 125 mg PO day 1 prior to chemotherapy, then 80 mg PO days 2 and 3 after chemotherapy Other: _____	Nausea / Vomiting

<b>PRN MEDICATIONS</b>	<input type="checkbox"/> Ondansetron (Zofran) _____ mg IV every _____ hours PRN <input type="checkbox"/> Prochlorperazine (Compazine) 5 - 10 mg PO/ IV every 6 hrs PRN if ondansetron (Zofran) ordered/ ineffective	Nausea/ Vomiting
<b>PRN MEDICATIONS</b>	<input type="checkbox"/> Lorazepam (Ativan) 0.5 – 2 mg PO/ IV every 4 hours PRN	Anxiety
<b>PRN MEDICATIONS</b>	<input type="checkbox"/> Acetaminophen (Tylenol) 325 – 975 mg PO every 4 hrs PRN. Not to exceed 4 g of acetaminophen/ 24 hrs	Temp greater than 38°C or Mild Pain
<b>PRN MEDICATIONS</b>	<input type="checkbox"/> Zolpidem (Ambien) 5 mg PO HS PRN insomnia (use 2.5 mg if 65 or older). May repeat X 1	Insomnia
<b>PRN MEDICATIONS</b>	<input type="checkbox"/> Senna/ docusate (Senokot-S) 8.6 mg/ 50 mg 2 tablets PO BID and Docusate 250mg PO BID (hold for loose stools). MOM Concentrate 10 mL PO daily PRN. If ineffective, give Polyethylene glycol (Miralax equiv) 17 g PO daily PRN	Constipation
<b>PRN MEDICATIONS</b>	<input type="checkbox"/> Loperamide (Imodium) 4 mg PO initially, then 2 mg PO after each loose stool up to a maximum of 16 mg/ per 24 hours	Diarrhea/ Loose Stools

<b>PRN RXN</b>	For symptoms of anaphylaxis, or for severe medication reaction, notify physician and administer the following stat: <ul style="list-style-type: none"> <li>▪ Diphenhydramine (Benadryl) 25 mg IV X 1. May repeat X 1 in 10 minutes</li> <li>▪ Dexamethasone (Decadron) 10 mg IV X 1</li> </ul>	Anaphylaxis/ Severe Reaction
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**Discharge Planning:** (Check box to activate)

Initiate *Outpatient Anticoagulation Orders* (P0190)

\_\_\_\_\_  
 Sign                  Date                  Time

Diagnosis:	Treatment Regimen: (please provide reference if new regimen or if varying from known protocol)		
Weight: _____ Kg	Height: _____ ft _____ Inches	Body Surface Area: _____ M <sup>2</sup>	Cycle #: _____

DAY # 1 = \_\_\_\_\_ (date)

**CHEMOTHERAPY:**

*Administer chemotherapy in the following sequence unless otherwise specified by physician  
Diluent and rate per Pharmacy chemotherapy preparation and administrative guidelines unless otherwise written by physician*

Drug # 1: _____	_____ mg per m <sup>2</sup>	Dose: _____ mg
Frequency: _____	Infuse over: _____	Route: _____
Administer on day(s): _____	Hold for: _____	
Drug # 2: _____	_____ mg per m <sup>2</sup>	Dose: _____ mg
Frequency: _____	Infuse over: _____	Route: _____
Administer on day(s): _____	Hold for: _____	
Drug # 3: _____	_____ mg per m <sup>2</sup>	Dose: _____ mg
Frequency: _____	Infuse over: _____	Route: _____
Administer on day(s): _____	Hold for: _____	
Drug # 4: _____	_____ mg per m <sup>2</sup>	Dose: _____ mg
Frequency: _____	Infuse over: _____	Route: _____
Administer on day(s): _____	Hold for: _____	
Drug # 5: _____	_____ mg per m <sup>2</sup>	Dose: _____ mg
Frequency: _____	Infuse over: _____	Route: _____
Administer on day(s): _____	Hold for: _____	

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time