Hartford Hospital
A Hartford HealthCare Partner

6804

**Level of Care:** ☐ In-patient ☐ Same-day ☐ Out-patient **Antineoplastic Drug Order Form**

**Start Date of This Order:** _____/_____/_____

**Diagnosis:** _____

**Height:**_____ **Weight:**_____

Date weighed: _____/_____/_____

**BSA:**_____**m²** **AUC:**_____(if applicable)

Regimen/Reference:_____

**Allergies:**

**Labs:** Date drawn_____
HCT:_____ WBC:_____ PLT:_____
BUN:_____ CREAT:_____ Other:_____

**Give Treatment:** (check one)

- ❑ If lab work meets the following parameters:

_____
_____

- ❑ Based on / Despite reviewed lab work of: _____/_____/_____ (list lab results if different than above)
- ❑ **Lab work not applicable**

**Drug Regimen: Drug, Dose/m² or kg, Route, Schedule, and Duration**

**Cycle #_____** Date last given:____/____/____

1.

2.

3.

4.

5.

Dose Adjusted? **Percent Adjusted:**

- ❑ Yes **_____% (reduction)**
- ❑ No

Rationale for Adjustment:

MD _____ ___/___/___ ___:___

RN #1 _____ ___/___/___ ___:___

RN #2 _____ ___/___/___ ___:___

R.Ph. #1 _____ ___/___/___ ___:___

**PRN & PREMEDICATIONS:**

**HYDRATION ORDERS: (PRE CHEMO, DURING, AND POST CHEMO FLUIDS)**

1. **DRUG:** **DOSE:** **ROUTE:**
**FREQUENCY:**
INSTRUCTIONS:

2. **DRUG:** **DOSE:** **ROUTE:**
**FREQUENCY:**
INSTRUCTIONS:

3. **DRUG:** **DOSE:** **ROUTE:**
**FREQUENCY:**
INSTRUCTIONS:

4. **DRUG:** **DOSE:** **ROUTE:**
**FREQUENCY:**
INSTRUCTIONS:

5. **DRUG:** **DOSE:** **ROUTE:**
**FREQUENCY:**
INSTRUCTIONS: