Adult Outpatient Chemotherapy Order Form *(page 1 of 1)*

Diagnosis / Indications: Breast Cancer

Regimen: AC (Dose Dense) - Q14DAYS

Cycle #: _____

References: Citron ML,, et al. *J Clin Oncol* 2003; 21:1431-9

Begin Therapy Day #1 (_____/_____/_____)

Patient Height: _____ **cm**

Weight: Actual _____ kg Ideal: _____ kg Used: _____ kg

Body Surface Area: Actual: _____ Ideal: _____ Used: _____

Allergies *(reactions)*: _____

Lifetime Dose Doxorubicin: _____

Chemotherapy:

	DRUG (Oral or injectable)	PROTOCOL DOSAGE (Per m² or Per kg)	PATIENT'S DOSE	ROUTE / FREQUENCY	GIVE ON DAYS
1	Doxorubicin	60 mg/m²		IV	Day 1
	Fluid / Volume: minimal volume ☐ EF on _____=_____%			Flow Rate or Infusion Time: 15 minutes	
2	Cyclophosphamide	600 mg/m²		IV	Day 1
	Fluid / Volume: 250 mL NS			Flow Rate or Infusion Time: 30 - 60 minutes	
3	☐ Filgrastim ☐ Pegfilgrastim	5 mcg/kg/day 6 mg		Subcutaneously Subcutaneously	Days 3 - 10 Day 2
4					
	Fluid / Volume			Flow Rate or Infusion Time	

Follow-up appt.: _____ **with labs** _____

Specific Administration Instructions/Requirements:

1. **Institute extravasation protocol in the event of a suspected extravasation**
   ☐ **ANC greater than 1,000** ☐ **ANC greater than 1,500** ☐ **Platelets greater than 100,000**
2. **Monitor for hypersensitivity / allergic reaction. If suspected, then follow hypersensitivity / anaphylaxis orders per the Emergency Physician's Order protocol.**

Labs: ☐ **CBC w/diff** ☐ **CMP** ☐ **BMP** ☐ **LFTs** ☐ **Other:** _____

Pre-Medications*)*:

1. Aprepitant 125 mg PO x 1 (Patient's own medication) 2. Dexamethasone 12 mg IV x 1 3. Ondansetron 8 mg IV x 1

PRN Medications *(please check appropriate meds)*:

☐ **Lorazepam 1 mg IV x 1** ☐ **Prochloperazine 10 mg IV x 1** ☐ **Promethazine 25 mg IV x 1**

Take Home Medications *(please check appropriate meds)*:

1. **Aprepitant 80 mg PO days 2 and 3 (#2)**
2. **Dexamethasone 8 mg PO every AM Days 2, 3 and 4 (#3)**

☐ **Prochloperazine 10 mg PO q6hr PRN nausea and vomiting (#_____) OR**

☐ **Promethazine 25 mg PO q6hr PRN nausea and vomiting (#_____)**

Special Instructions / Extra Orders: _____

Date _____ **Time** _____ **Physician / PA / RPh** _____ **Provider #** _____ **Beeper #** _____

Date _____ **Time** _____ **Signature of Oncology Attending / Fellow** _____ **MD**

Print Name of Attending / Fellow _____ **MD#** _____

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Shands at the University of Florida
Gainesville, Florida 32610

RX0001

Patient Name: Patient Identification #:

Date printed5/27/09

5/22/09
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