Instructions for use – Fill 2 copies of these prescription sheets every time the patient comes to hospital. Keep a copy in the case note and give one to the patient as personal record

IV Chemotherapy Pre-Order and Prescription Form **Sheet No:**

CLASSICAL CMF X 6 (Adjuvant Tx for Breast)

Date:

Hospital No:

Surname:

First Name:

Age:

Sex:

Cyclophosphomide **100mg/m2 per oral on days 1 - 14**

Methotrexate **40mg/m2 days 1 and 8**

Fluorouracil **600mg/m2 days 1 and 8 cycled every 28 days**

This is treatment no:		Clinic/ Ward Consultant		Height Weight BSA	cm Kg m2
Stage		Ordered by (signed by)		Confirmed by	

This is treatment no:	**Drugs**	**Dose**	**Vol., Route & Duration**	**Date Required**	**Drugs**	**Dose**	**Vol., Route & Duration**
Day 1 FBC result **PCV (>30%) =** **WBC (>2,500 cells/cc) =** **PLATELETS (>100,000 cells/cc) =**	**Methotrexate** Please circle choice of dose- *State reason for using unlisted dose*	40mg 50mg + 5mg 60mg 70mg 80mg Other	Dilute to 25 mg/ml and give by bolus IV over 2 mins	**Day 8** FBC result **PCV (>30%) =** **WBC (>2,500 cells/cc) =** **PLATELETS (>100,000 cells/cc) =**	**Methotrexate** Please circle choice of drug- *State reason for using unlisted dose*	40mg 50mg +5mg 60mg 70mg 80mg Other	Dilute to 25 mg/ml and give by bolus IV over 2 mins
	Fluorouracil Please circle choice of dose- *Reason for using unlisted dose*	800mg 900mg 1000mg + 50mg 1100mg 1200mg Other	Dilute to 50 mg/ml and infuse in 1 L of Normal saline		**Fluorouracil** Please circle choice of dose- *Reason for using unlisted dose*	800mg 900mg 1000mg +50mg 1100mg 1200mg Other	Dilute to 50 mg/ml and infuse in 1 L of Normal saline
	Cyclophosphomide tablets in 50 mg per tabs may be given either as 50 mg b.d.; t.d.s. or q.d.s. for 14 days depending on body surface area						

Sign the appropriate box below on day of treatment to indicate what should be done

Give treatment as prescribed	Dose has changed – see new prescription	Stop all Treatment	Give treatment as prescribed	Dose has changed – see new prescription	Stop all Treatment
Defer treatment until (insert Date)	Change of Treatment		Defer Until (insert Date)	Change of Treatment	

Indicate anti-emetics if any below

Version date: Saturday, June 16, 2007