

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:**

<b>Date:</b>		<b>BEP (Germ Cell Ovarian cancer)</b>		<b>Hospital No:</b>	
<b>No. of Cycles patient should get =</b>		Etoposide 100mg/m2 days 1 to 5 Cisplatin 20mg/m2 days 1 to 5 Bleomycin 30 units on days 1, 8 and 15 <b>Every 3 weeks, 3 courses followed by VAC</b>		<b>Surname:</b>	
				<b>First Name:</b>	
				<b>Age:</b>	
				<b>Sex:</b>	
Diagnostic Group	Ovarian	Clinic/ Ward		Height	cm
Stage		Consultant		Weight	Kg
Status				BSA	m2
<b>Date Required</b>	<b>Drugs</b>	<b>Dose</b>	<b>Vol., Route &amp; Duration</b>		
<b>Day 1</b>	<b>Etoposide</b>	150mg	IV infusion of 20mg/ml/6 minutes		
<b>FBC</b>	Please circle choice of dose- <i>State reason for using unlisted dose below</i>	160mg			
PCV =		170mg + 5mg			
WBC =		180mg			
PLAT =		190mg			
		200mg			
	<b>Cisplatin</b>	20mg	IV infusion in 250 ml of normal saline		
	Please circle choice of dose- <i>State reason for using unlisted dose below</i>	30mg+ 5mg			
		40mg			
		Other			
<b>Day 8</b>	<b>Bleomycin</b>	20units	IV push over 10 mins		
<b>FBC</b>	Please circle choice of dose- <i>State reason for using unlisted dose below</i>	30units + 5units			
PCV =		40units			
WBC =		Other			
PLAT =					

**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	

**Antiemetics**

Name	Dose	Vol	Route	Name	Dose	Timing	Days
Ondasetron	10 mg	Bolus	IV	Ondasetron tablets	8 mg	b. d.	
OR Other HT3 receptor antagonist							
Dexamethasone	10 mg	Bolus	IV	Dexamethasone tablets	4 mg	t. d. s.	