

| | | | | | | | | | | | | | | | |
|------------|------------|--|-------------|--|--------------------|--|--|--|--|--|--|--|--|------------|-------------|
| Forename | Surname | | Protocol | | | | | | | | | | | SA (m²) | |
| | | | Course Name | Lonsurf (Trifluridine/Tipiracil) for colorectal ca | | | | | | | | | | Height (m) | |
| DOB | Patient NO | | Local No. | NHS No | | | | | | | | | | | Weight (kg) |
| | | | | | | | | | | | | | | | |
| Consultant | | | Ward | Diagnosis | Carcinoma of Colon | | | | | | | | | | |
| Address | | | | | | | | | | | | | | | |

Record drug allergies or sensitivities

| | | | | Time | Date | | | | | | | | | | | | | |
|--------------------|--|----------------|------------|----------|------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | | | | | | | | | | |
| Drug & dose | LONSURF | | | | | | | | | | | | | | | | | |
| Actual dose | | | Duration | DAYS 1-5 | | | | | | | | | | | | | | |
| Route | PO | | Start Date | | | | | | | | | | | | | | | |
| Frequency | BD | | Start Day | 1 | | | | | | | | | | | | | | |
| Quantity Dispensed | | Dispensed by | | | | | | | | | | | | | | | | |
| | | Accuracy check | | | | | | | | | | | | | | | | |
| Note | Please dispense Lonsurf (Trifluridine/Tipiracil) tablets. Dose expressed in terms of Trifluridine. | | | | | | | | | | | | | | | | | |
| Drug & dose | METOCLOPRAMIDE | | | | | | | | | | | | | | | | | |
| Actual dose | 10 mg | | Duration | PRN | | | | | | | | | | | | | | |
| Route | PO | | Start Date | | | | | | | | | | | | | | | |
| Frequency | TDS | | Start Day | 1 | | | | | | | | | | | | | | |
| Quantity Dispensed | | Dispensed by | | | | | | | | | | | | | | | | |
| | | Accuracy check | | | | | | | | | | | | | | | | |
| Note | If pre-pack supplied record Batch Number : _____. | | | | | | | | | | | | | | | | | |

| | | | | |
|---------------|---------------|----------------|--------------------------|--|
| Allocated by: | Confirmed by: | Authorised by: | Checked by: (Pharmacist) | |
| Date: | Date: | Date: | Date: | |
| / / | / / | / / | / / | |

Patient Details

| | | | | | | | | | | | | | | | |
|----------|------------|--|-------------|--|--|--|--|--|--|--|--|--|--|------------|-------------|
| Forename | Surname | | Protocol | | | | | | | | | | | SA (m²) | |
| | | | Course Name | Lonsurf (Trifluridine/Tipiracil) for colorectal ca | | | | | | | | | | Height (m) | |
| DOB | Patient NO | | Local No. | NHS No | | | | | | | | | | | Weight (kg) |
| | | | | | | | | | | | | | | | |
| | | | Ward | | | | | | | | | | | | |
| Address | | | | | | | | | | | | | | | |

Record drug allergies or sensitivities

| | | | | | | | | | | | | | | | | | | |
|--------------------|---|----------------|------------|-----------|------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | | | | Time | Date | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| Drug & dose | LOPERAMIDE | | | | | | | | | | | | | | | | | |
| Actual dose | 2 mg | | Duration | | | | | | | | | | | | | | | |
| Route | PO | | Start Date | | | | | | | | | | | | | | | |
| Frequency | SEE NOTE | | Start Day | 1 | | | | | | | | | | | | | | |
| Quantity Dispensed | | Dispensed by | | | | | | | | | | | | | | | | |
| | | Accuracy check | | | | | | | | | | | | | | | | |
| Note | Take 4mg after first loose stool then 2mg after each loose stool thereafter upto a maximum of 8 cap/tabs in 24 hours. If pre-pack supplied record Batch Number : _____. | | | | | | | | | | | | | | | | | |
| Drug & dose | LONSURF | | | | | | | | | | | | | | | | | |
| Actual dose | | | Duration | DAYS 8-12 | | | | | | | | | | | | | | |
| Route | PO | | Start Date | | | | | | | | | | | | | | | |
| Frequency | BD | | Start Day | 8 | | | | | | | | | | | | | | |
| Quantity Dispensed | | Dispensed by | | | | | | | | | | | | | | | | |
| | | Accuracy check | | | | | | | | | | | | | | | | |
| Note | Please dispense Lonsurf (Trifluridine/Tipiracil) tablets. Dose expressed in terms of Trifluridine. | | | | | | | | | | | | | | | | | |

| | | | | |
|---------------|---------------|----------------|--------------------------|--|
| Allocated by: | Confirmed by: | Authorised by: | Checked by: (Pharmacist) | |
| Date: | Date: | Date: | Date: | |
| / / | / / | / / | / / | |