Test treatment location

Parenteral Cytotoxic Chart

Chemocare prescription v1.01

Patient Details

Forename **Surname**

Address

DOB | Patient NO | Local No.

Consultant | Ward

NHS No

Protocol

Course Name: R-ICE (Rixathon)

Type of line
No. of lumen:

Diagnosis

SA (m²)
Height (m)
Weight (kg)

Monitoring	Acceptable Range		Date Due	Date of Test	Value	Checked
Height (m)						
Weight (kg)						
SA (m²)						
BILIRUBIN	0.00	21.00	Day 1			
COCKCROFT (>60)	60.00	300.00	Day 1			
NEUTROPHILS > 1.0	1.00	15.00	Day 1			
PLATELETS>90	90.00	600.00	Day 1			

Additional Prescribing Notes

Monitor patient for signs of ifosfamide toxicity- contact medicial staff if signs of drowsiness or confussion are noticed.

For inpatients prescribe antiemetics and other ancillary non-cytotoxics on e-record

Rituximab: Follow Trust Guidelines for the Administration of Rituximab Infusions.

Day	Date and Time	Drug and dose (per m2) or dose (per kg)	ACTUAL DOSE	Infusion Fluid and Final Volume	Route	Additives	Time/Infusion Rate	Line	Given/ Checked by	Time Start/ Stop	Comments
1	T=hrs	HYDROCORTISONE (100mg)	100 mg	None	**IV**		Slow Bolus		Batch No.		To be given 30-60 minutes prior to rituximab infusion.
1	T=hrs	PARACETAMOL (1000mg)	1000 mg	None	**PO**				Batch No.		To be given 30-60 minutes prior to rituximab infusion.
1	T=hrs	CHLORPHENAMINE (10mg)	10 mg	None	**IV**		Slow Bolus		Batch No.		To be given 30-60 minutes prior to rituximab infusion.
1	T=:hrs	RITUXIMAB (RIXATHON) (375mg/m²)	mg	SODIUM CHLORIDE 0.9% 500 ml	**IV**				Batch No.		Rixathon brand. Variable infusion rate - see additional prescribing notes.

Allocated by:	Confirmed by:	Authorised by:	Checked by: (Pharmacist)		
Date:	Date:	Date:	Date:	Parenteral	3
				Intrathecal	1
				Oral	3

Test treatment location

Parenteral Cytotoxic Chart

Chemocare prescription v1.01

Patient Details

Forename **Surname**

Address

DOB | Patient NO | Local No.

Ward

NHS No

Protocol

Course Name: R-ICE (Rixathon)

SA (m²)
Height (m)
Weight (kg)

Day	Date and Time	Drug and dose (per m2) or dose (per kg)	ACTUAL DOSE	Infusion Fluid and Final Volume	Route	Additives	Time/Infusion Rate	Line	Given/ Checked by	Time Start/ Stop	Comments
1	T=hrs	**ETOPOSIDE** (100mg/m²)	mg	SODIUM CHLORIDE 0.9% 500 ml	**IV**		Infuse over 1 Hrs at a rate 500 ml/hr		Batch No.		
2	T=hrs	**CARBOPLATIN** (AUC5)	mg	Glucose 5% 500 ml	**IV**		Infuse over 1 Hrs at a rate 500 ml/hr		Batch No.		Max dose: 800mg
2	T=:hrs	**ETOPOSIDE** (100mg/m²)	mg	SODIUM CHLORIDE 0.9% 500 ml	**IV**		Infuse over 1 Hrs at a rate 500 ml/hr		Batch No.		
2	T=:hrs	MESNA (1000mg/m²)	mg	None	**IV**		Slow Bolus		Batch No.		Inject immediately before ifos+mesna infusion
2	T=:hrs	**IFOSFAMIDE** (2500mg/m²)	mg	Glucose 4% in sodium chloride 0.18% 1000 ml	**IV**	MESNA _____mg	Infuse over 12 Hrs at a rate 83 ml/hr		Batch No.		
2	T=hrs	**IFOSFAMIDE** (2500mg/m²)	mg	Glucose 4% in sodium chloride 0.18% 1000 ml	**IV**	MESNA _____ mg	Infuse over 12 Hrs at a rate 83 ml/hr		Batch No.		
3	T=:hrs	**ETOPOSIDE** (100mg/m²)	mg	SODIUM CHLORIDE 0.9% 500 ml	**IV**		Infuse over 1 Hrs at a rate 500 ml/hr		Batch No.		

Allocated by:	**Confirmed by:**	**Authorised by:**	**Checked by: (Pharmacist)**
Date:	**Date:**	**Date:**	**Date:**

Test treatment location

Parenteral Cytotoxic Chart

Chemocare prescription v1.01

Patient Details

Forename **Surname**

Address

DOB | Patient NO | Local No.

Ward

NHS No

Protocol

Course Name: R-ICE (Rixathon)

SA (m²)
Height (m)
Weight (kg)

Day	Date and Time	Drug and dose (per m2) or dose (per kg)	ACTUAL DOSE	Infusion Fluid and Final Volume	Route	Additives	Time/Infusion Rate	Line	Given/ Checked by	Time Start/ Stop	Comments
3	**T=:hrs**	MESNA (3000mg/m²)	mg	SODIUM CHLORIDE 0.9% 500 ml	**IV**		Infuse over 12 Hrs at a rate 42 ml/hr		Batch No.		Give immediately afer finishing last Ifos+mesna infusion

Allocated by:	**Confirmed by:**	**Authorised by:**	**Checked by: (Pharmacist)**
Date:	**Date:**	**Date:**	**Date:**

Test treatment location
Chemotherapy Prescription Chart

Patient Details

Forename | Surname | Ward | SA (m²)

DOB | Patient NO | Local No. | Consultant

NHS No

Patient ID checked by
Doctor / Nurse
Sign .....
Print .....
Date .....

Diagnosis

Address

Course Name: R-ICE (Rixathon)

Protocol

Treatment Location:

Pharmacy Location: Newcastle Teaching

Additional Notes for

Cytarabine Batch number_____Expiry date_____
Hydrocortisone Batch number_____Expiry date_____
Methotrexate Batch number_____Expiry date_____

Day	Date and Time	Drug	Single Dose	Route	Drugs Checked By	Drugs Given By	Time Given / Batch No.
4		**CYTARABINE**	**25 mg**	**INTRATHECAL**	**Doctor** Sign **Nurse** Sign	**Doctor** Sign **Witnessed Nurse** Sign	
4		**HYDROCORTISONE**	**50 mg**	**INTRATHECAL**	**Doctor** Sign **Nurse** Sign	**Doctor** Sign **Witnessed Nurse** Sign	
4		**METHOTREXATE**	**12.5 mg**	**INTRATHECAL**	**Doctor** Sign **Nurse** Sign	**Doctor** Sign **Witnessed Nurse** Sign	

Allocated by : **Date:**	**Confirmed by :** **Date:**	**Authorised by :** **Date:**	**Checked by : (Pharmacist)** **Date:**

Release from Pharmacy and Acceptance in Clinical Area

Part A (NB Both sections below must be completed before chemotherapy can be released)

Is IV/SC/IM chemotherapy due to be given prior to todays dose(s)?	Yes/No/NA	Sign
Has pharmacist seen evidence that the IV/SC/IM chemotherapy has been administered?	Yes/No/NA	Sign

Part B (NB One of the sections below must be fully completed before administration can proceed)

Either 1	Issued from pharmacy by authorised member of pharmacy staff (signature):	Sign	Print Name	Date	Time
	Received by authorised doctor (signature):	Sign	Print Name	Date	Time
Or 2	Delivered to designated area and stored as defined in local policy by authorised member of pharmacy staff (signature):	Sign	Print Name	Date	Time
	Retrieved from designated storage area as defined in local policy, by authorised doctor (signature):	Sign	Print Name	Date	Time
Or 3	Delivered to designated area by authorised member of pharmacy staff and issued directly to authorised doctor by (signature) :	Sign	Print Name	Date	Time
	Received by authorised doctor (signature):	Sign	Print Name	Date	Time

NB Only staff who have been trained and whose name is listed on the relevant registers for chemotherapy may prescribe prepare, issue, deliver, check and administer chemotherapy

Patient Details

Forename	**Surname**	**Protocol**		**SA (m²)**
		Course Name	R-ICE (Rixathon)	**Height (m)**
DOB	**Patient NO**	**Local No.**	**NHS No**	**Weight (kg)**
Consultant		**Ward**	**Diagnosis**	
Address				

Record drug allergies or sensitivities

				Time	**Date**													
Drug & dose	ONDANSETRON																	
Actual dose	8 mg	**Duration**	5 DAYS															
Route	PO	**Start Date**																
Frequency	BD	**Start Day**	1															
Quantity Dispensed		**Dispensed by**																
		Accuracy check																
Note	If pre-pack supplied record Batch Number :_____.																	
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	Discuss with patient and delete if supply not required. If pre-pack supplied record Batch Number :_____.																	

Allocated by: **Date:**	**Confirmed by:** **Date:**	**Authorised by:** **Date:**	**Checked by: (Pharmacist)** **Date:**	

Patient Details

Forename	**Surname**	**Protocol**		**SA (m²)**
		Course Name	R-ICE (Rixathon)	**Height (m)**
DOB	**Patient NO**	**Local No.**	**NHS No**	**Weight (kg)**
		Ward		
Address				

Record drug allergies or sensitivities

				Time	**Date**													
Drug & dose	ACICLOVIR																	
Actual dose	200 mg	**Duration**	21 DAYS															
Route	PO	**Start Date**																
Frequency	TDS	**Start Day**	1															
Quantity Dispensed		**Dispensed by**																
		Accuracy check																
Note	Continuous treatment supply original packs																	
Drug & dose	CO-TRIMOXAZOLE																	
Actual dose	960 mg	**Duration**	MonWedFri															
Route	PO	**Start Date**																
Frequency	OD	**Start Day**	1															
Quantity Dispensed		**Dispensed by**																
		Accuracy check																
Note	Continuous treatment																	

Allocated by: **Date:**	**Confirmed by:** **Date:**	**Authorised by:** **Date:**	**Checked by: (Pharmacist)** **Date:**	

Patient Details

Forename	**Surname**	**Protocol**		**SA (m²)**
		Course Name	R-ICE (Rixathon)	**Height (m)**
DOB	**Patient NO**	**Local No.**	**NHS No**	**Weight (kg)**
		Ward		
Address				

Record drug allergies or sensitivities

				Time	**Date**													
Drug & dose	FILGRASTIM (G-CSF)																	
Actual dose	microgram	**Duration**	9 DAYS															
Route	SC	**Start Date**																
Frequency	OD	**Start Day**	6															
Quantity Dispensed		**Dispensed by**																
		Accuracy check																
Note	SUBCUTANEOUS BOLUS																	

Allocated by: **Date:**	**Confirmed by:** **Date:**	**Authorised by:** **Date:**	**Checked by: (Pharmacist)** **Date:**	