


# CYCLOPHOSPHAMIDE PHYSICIAN'S ORDER SHEET

- Do not add or change orders in any section where orders have previously been written
- \* Elder alert (lower dose/treatment recommended if patient is greater than 65 years old)

<input checked="" type="checkbox"/> Standard Orders <input type="checkbox"/> Requires a check (✓) for activation		
Drug Allergies/Intolerance <i>(List and provide description of reaction)</i> _____	ORDER TRANSCRIBED AND ACTIVATED	Patient's Height _____ Patient's Weight _____ Patient's Body Surface Area _____
MEDICATION and INTRAVENOUS ORDERS	 TEST DONE	GENERAL ORDERS
ORDER DATE _____ TIME _____ CYCLOPHOSPHAMIDE CYCLE # _____ DATE OF SCHEDULED INFUSION _____  1. Insert peripheral IV. 2. Hydrate starting 2 hours pre-cyclophosphamide. Check one or more (✓): <input type="checkbox"/> 0.9% Normal saline 250 mL/hr IV x 4 hours <input type="checkbox"/> 0.9% Normal saline 1 L with Mesna _____ mg (usual dose equivalent to cyclophosphamide dose) administer 250 mL/hr 1 L x 4 hours <input type="checkbox"/> Furosemide _____ mg IV x 1 dose post normal saline infusion 3. Ondansetron _____ mg (usual dose 8 mg) IV 30 minutes pre-cyclophosphamide. 4. Cyclophosphamide _____ mg (usual dose 500 - 1000 mg/m <sup>2</sup> Body Surface Area) IV over 1 hour in 250 mL of D5W 5. Discharge prescription for: Ondansetron 8mg PO q8h x 3 doses for nausea/ vomiting. 6. Patient may take own medications. 7. Remove IV at discharge _____	1. Admit under Dr. _____ 2. Admitting Procedure: IV cyclophosphamide 3. Admitting Diagnosis: _____ 4. Vital signs. Monitor blood pressure and heart rate: <input checked="" type="checkbox"/> prior to start of infusion <input checked="" type="checkbox"/> then q 1h 5. If diabetic accuchecks q _____ hours <input checked="" type="checkbox"/> Notify admitting doctor if glucose less than 5 or greater than 20 6. Diet as tolerated. 7. Activity as tolerated. 8. Notify physician: <input checked="" type="checkbox"/> Pre-initiation of IV cyclophosphamide <input checked="" type="checkbox"/> Immediately should patient have anaphylactic type reaction (dyspnea, angioedema, and urticaria) 9. Blood work Pre IV cyclophosphamide: check one or more (✓): <input type="checkbox"/> No laboratory studies required <input type="checkbox"/> Na, K, Cl, TCO <sub>2</sub> , Urea, Creatinine <input type="checkbox"/> CBC (STAT) <input type="checkbox"/> Ca <sup>2+</sup> , PO <sub>4</sub> , Albumin <input type="checkbox"/> AST, ALT, ALP, GGT <input type="checkbox"/> ANA <input type="checkbox"/> C3, C4 <input type="checkbox"/> CRP, ESR <input type="checkbox"/> Other: _____ 10. Urine tests pre or post IV cyclophosphamide check one or more (✓): <input type="checkbox"/> No urine studies required <input type="checkbox"/> Urinalysis <input type="checkbox"/> Urine PCR 11. Discharge patient post IV cyclophosphamide if: <input checked="" type="checkbox"/> Vital signs stable <input checked="" type="checkbox"/> No other nursing concerns	
PHYSICIAN'S SIGNATURE _____  PRINTED NAME _____  _____ <small>GENERIC EQUIVALENT AUTHORIZED</small>		<b>PAGE 1 OF 1</b>