

## Patient Details

Title \_\_\_\_\_ Surname \_\_\_\_\_  
 Given Names \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Ph. \_\_\_\_\_  
 Address \_\_\_\_\_  
 State \_\_\_\_\_ Postcode \_\_\_\_\_  
 PICC Insitu  Yes  No Portacath  Yes  No Cannulation Req.  Yes  No  
 Chemotherapy Cycle - Home Days \_\_\_\_\_ Clinic Days \_\_\_\_\_

<b>Medication Alert (Allergies)</b>	
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## Administration Record

Height (cm)	Weight (kg)	BSA (m <sup>2</sup> )	Date							
			Hb (g/L)							
<b>Diagnosis and Stage</b>			Platelets (x 10 <sup>9</sup> /L)							
			WBC (x 10 <sup>9</sup> /L)							
			Neutrophils (x 10 <sup>9</sup> /L)							
			Creatinine (umol/L)							
<b>Treatment Protocols</b>			Others							
			PICC line length (cm)							
			Course No.	Course No.	Course No.	Course No.	Course No.	Course No.		
			Date	Date	Date	Date	Date	Date		

Pre Medication	Dose/Route	Duration/Carrier	Start Date	End Date	Sign/Time	Sign/Time	Sign/Time	Sign/Time	Sign/Time	Sign/Time

Cytotoxic Therapy	Dose/Route	Duration/Carrier	Start Date	End Date	Sign/Time	Sign/Time	Sign/Time	Sign/Time	Sign/Time	Sign/Time

Post Treatment	Dose/Route	Duration/Carrier	Start Date	End Date	Sign/Time	Sign/Time	Sign/Time	Sign/Time	Sign/Time	Sign/Time

<b>M.O. Signature</b>	<b>Consent:</b> I have informed the patient/representative of the nature, likely results and risks associated with this treatment.
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## Medical Oncologist Details

Prescriber No. \_\_\_\_\_ Provider Name \_\_\_\_\_ Ph. \_\_\_\_\_