NAMED PATIENT CHEMOTHERAPY ORDER FORM

(December 2017 – Version 5)

Please fax with an accompanying cover note to 020 8838 8261
Please call to confirm receipt of order on 020 8838 8272

ITH Pharma DOES NOT take any clinical responsibility for prescribed chemotherapy.
Please allow 48hrs of turnaround time from when the order is received. Orders received after 12pm will be treated as received the following day.
Use ONE form per patient per cycle. Please print clearly using black ink.

Patient Name		**Hospital & Delivery Address**
Hospital Number		
Date of Birth		
Order Number		**Contact No:**

Date/time drugs to be received by (Please put **X**)	Pre 10:30am	Pre 12pm	Pre 2pm	Same Day AM	Same Day PM
Date/time patient due to receive treatment					

	Drug Name	**Final Container**	**Dose (mg)**	**Route (e.g. IVB)**	**Diluent**	**Total Volume (mls)**	**Quantity**	**FOR ITH USE ONLY**	
								Final Chk.	**Release**
1									
2									
3									
4									

Additional requirements (Please state)	

Name of Person Ordering:_____ Position:_____

Signature:_____ Date:_____

ITH PHARMA USE ONLY

SCHEDULING

Scheduled By:

Manufacture Date/Time:

Delivery Date/Time:

Delivery Type/Time: (circle)

S/D: AM PM @

O/N: Pre 10:30am Pre 12pm Pre 2pm

INVOICING

Invoiced By:

Checked By:

Invoice No:

Prepared By: Sunmeet Kaur (Deputy Unit Manager) Checked By: Zahedul Khan (Senior Deputy Unit Manager)