# NAMED PATIENT CHEMOTHERAPY ORDER FORM

(November 2011 – Version 4)

**Please fax with an accompanying cover note to 020 8838 8281**
**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** | | |
| **Body Surface Area** | | |
| **Order Number** | | **Contact No:** |

| | | | | |
|---|---|---|---|---|
| Date/time drugs to be received by (please circle) | Pre 10am | Pre 12pm | Pre 2pm | Same Day |
| Date/time patient due to receive treatment | | | | |

| | Drug Name | Dose (mg) | Route (e.g. IVB) | Diluent | Total Volume (mls) | Quantity | FOR ITH USE ONLY | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | Final Chk. | Release |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |

Name of Person Ordering:_____ Position:_____

Signature:_____ Date:_____

**ITH PHARMA USE ONLY**

SCHEDULING
Scheduled By:
Manufacture Date:
Delivery Date:
Delivery Type/Time: (circle)

S/D: AM PM @
O/N: Pre 10am Pre 12pm
Pre 2pm

INVOICING
Invoiced By:
Checked By:
Invoice No:

Prepared By: Simon Boyes (Unit Manager) Checked By: Karen Hamling (Managing Director)