NAMED PATIENT CHEMOTHERAPY ORDER FORM

(November 2011 – Version 4)

Please fax with an accompanying cover note.
Please call to confirm receipt of order.

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)