

BATCH CHEMOTHERAPY ORDER FORM

(December 2017 – Version 5)

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

Please allow 72hrs of turnaround time from when the order is received. Orders received after 12pm will be treated as received the following day.
Please print clearly using black ink.

Hospital & Delivery Address

Contact No:

Order No:

Date/time drugs to be received by (Please put X)	Pre 10:30am	Pre 12pm	Pre 2pm	Same Day AM	Same Day PM
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	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									
5									

**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)