

RM #	PT NAME	MRN #	DOB	ADMIT	DIAGNOSIS	ALLERGIES	CODE	ISOLATION	DIET
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PAST ONCOLOGY TREATMENT HISTORY

PAST COMPLETED TX	PAST COMPLICATIONS/ADVERSE EFFECTS
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DOCUMENT [EXACT TIME]	INTERVENTIONS
[TIME]	
[TIME]	
[TIME]	
[TIME]	
[TIME]	
[TIME]	
[TIME]	
[TIME]	
[TIME]	
[TIME]	
[TIME]	
[TIME]	
[TIME]	
[TIME]	
[TIME]	

CURRENT ONCOLOGY TREATMENT PLAN

STAGE OF CANCER	TUMOR SIZE/LOCATION	CYCLE	TYPE OF TX
PROCEDURES/CONSULTS			VENOUS ACCESS

CANCER TX ADMINISTRATION CHECKLIST [C.A.N.C.E.R + 11 pt. rights]

- CHANGE INTO NEUROPENIC PPE**
 - gown, mask, eye protection, double gloves
 - ASSESSMENT**
 - right patient* – WRISTABAND, COMPUTER, MED [NAME, DOB, MRN#]
 - right assessment* – IV, LABS, ASSESS PT, ALLERGIES, CONTRADICTIONS
 - Determine if patient needs antiemetic or blood transfusion
 - NOTIFY 2ND RN TO CROSS CHECK**
 - right reason:* _____
 - right drug* – MED: _____
 - right dosage:* _____ ml/hr | tablet
 - right route:* _____
 - right timing:* start time [TIME] start end [TIME]
 - COMMUNICATE**
 - right education* – DURATION, PROCEDURE, TREATMENT, PRECAUTIONS
 - right to refuse:* y / n
 - EVALULATE**
 - right reaction* – s/s, tolerated well?
 - Take vitals Q15 minutes for 1 hour & stay one to one to monitor
- 15mins [TIME] BP: / HR: TEMP: O2: PAIN: S/S:
30 mins [TIME] BP: / HR: TEMP: O2: PAIN: S/S:
45 mins [TIME] BP: / HR: TEMP: O2: PAIN: S/S:
60 mins [TIME] BP: / HR: TEMP: O2: PAIN: S/S:
- RECORD DATA**
 - right documentation*

BLOOD TRANSFUSION CHECKLIST

PRE-VITALS [TIME]	BLOOD TRANSFUSION	POST-VITALS [TIME]
BP: /	TIME:	BP: /
HR:	RATE:	HR:
TEMP:	BLOOD TYPE:	TEMP:
O2:	OBSERVATIONS:	O2:
PAIN:	ACCEPTABLE PAIN:	PAIN:

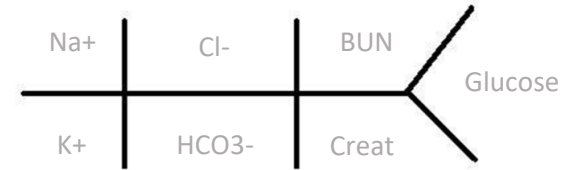
NEXT TREATMENT/FOLLOW UP:

POST TREATMENT CARE:

RM #	PT NAME	MRN #	DOB	ADMIT	DIAGNOSIS	ALLERGIES	CODE	ISOLATION	DIET
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TIME	MED PASS	PLAN OF CARE	NURSING PRIORITIES
0700/1900	<input type="checkbox"/>		
0800/2000	<input type="checkbox"/>		
0900/2100	<input type="checkbox"/>		
1000/2200	<input type="checkbox"/>		
1100/2300	<input type="checkbox"/>		
1200/2400	<input type="checkbox"/>		
			PATIENT GOALS
1300/0100	<input type="checkbox"/>		
1400/0200	<input type="checkbox"/>		
1500/0300	<input type="checkbox"/>		
1600/0400	<input type="checkbox"/>		
1700/0500	<input type="checkbox"/>		
1800/0600	<input type="checkbox"/>		
			PAST MEDICAL HX

LABS



HEALTHCARE TEAM	PHONE
Oncologist:	Ext.
Cancer Outpatient:	Ext.
Lab:	Ext.
Charge RN:	Ext.
Resource RN:	Ext.
Unit Secretary:	Ext.

<p>INTEGUMENTARY</p> <p><i>CAPILLARY REFILL:</i></p> <p><i>MUCOUS MEMBRANE:</i></p> <p><i>SKIN:</i></p>	<p>MUSCULOSKELETAL</p> <p><i>RUE:</i></p> <p><i>LUE:</i></p> <p><i>RLE:</i></p> <p><i>LLE:</i></p>	<p>NEURO</p> <p><i>A&O:</i></p> <p><u><i>SENSATION</i></u></p> <p><i>RUE:</i></p> <p><i>LUE:</i></p> <p><i>RLE:</i></p> <p><i>LLE:</i></p>	<p>CARDIAC</p> <p><i>IV/PICC:</i></p> <p><i>S1:</i></p> <p><i>S2:</i></p> <p><i>PULSES:</i></p> <p><i>RATE/RHYTM:</i></p> <p><i>EDEMA:</i></p> <p><i>HR:</i></p>	<p>PULMONARY</p> <p><i>RUL:</i></p> <p><i>LUL:</i></p> <p><i>RLL:</i></p> <p><i>LLL:</i></p> <p><i>RR:</i></p> <p><i>O2:</i></p> <p><i>TUBES/LINES:</i></p>	<p>GI/GU</p> <p><i>BREAKFAST: MEAL ___ %</i></p> <p><i>LUNCH: MEAL ___ %</i></p> <p><i>DINNER: MEAL ___ %</i></p> <p><i>FLUID INTAKE:</i></p> <p><i>FLUID OUTPUT:</i></p> <p><i>BM COLOR _____ [DATE]</i></p> <p><i>URINE _____ ML [DATE]</i></p> <p><i>TUBES/LINES:</i></p> <p><i>ABD ASCULTATION:</i></p> <p><i>ABD INSPECTION:</i></p>
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