Chemotherapy Trained Professional's Checklist - **To be faxed to Pharmacy when answers are all "Yes"**	Yes	No
1) Is the chemotherapy copy legible? Print MD Name:_____		
2) Is appropriate intravenous access available?		
3) Is the chemotherapy protocol or substantiating literature available?		
4) Are the height, weight, and BSA (± 10%) accurate?		
5) Are the chemotherapy doses accurate (± 10% of physician calculations) or comments available explaining protocol modifications?		
6)Does the chemotherapy order indicate frequency and length of therapy?		
7) Are relevant hydration and antiemetic(s) ordered?		
8) Are the labs checked and approved?		
9) When is the chemotherapy scheduled to begin? Date:_____ Time:_____		

_____ _____

RN/MD/PA Date/Time Pager Extension

(fax checklist with chemotherapy orders and, if applicable, substantiating literature)

Pharmacist's Checklist	Yes	No
1) Is the Chemotherapy Trained Professional's Checklist complete?		
2) Is the chemotherapy protocol or substantiating literature available?		
3) Is the BSA calculated correctly (± 10%)?		
4) Are the chemotherapy doses appropriate or comments available explaining protocol modifications?		
5) Are relevant hydration and antiemetics ordered?		
6) Does the chemotherapy order indicate frequency & length of therapy?		
7) Chemotherapy is scheduled to begin on _____ (Date) _____ (Time)		

_____ _____

Chemotherapy Trained Pharmacist Date/Time Pager Extention

(Send checklist with chemotherapy)

Chemotherapy Delivery Verification

_____ _____

Pharmacy Delivery Personnel Date/Time RN/MD/PA Date/Time

2nd Independent Chemotherapy Competent Professional Verification: Complete Before Chemotherapy Administration

1) Dosing calculations are correct. 2) Ordered drug and dose accuracy is based on a published regimen.

_____ _____

RN/MD/PA Date/Time Pager Extension

(The completed checklist is to be placed in the medical record)

ADDITIONAL FORMS MAY BE OBTAINED FROM UTMB PRINTING SERVICES BY CALLING 409.772.5900

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

CHEMOTHERAPY CHECKLIST

Department of Nursing Services

Medical Record Form 5701-Rev. 9/17
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original–Medical Record