

Patient Details

Forename _____ Surname _____

Protocol DECC LYMPHOMA

Address _____

DOB _____ Patient NO _____ Local No. _____

Course Name: DECC Lymphoma

Consultant _____ Ward _____ Type of line _____

NHS No _____ No. of lumen: _____

Diagnosis _____

SA (m²)

Height (m)

Weight (kg)

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Monitoring	Acceptable Range		Date Due	Date of Test	Value	Checked
Height (m)						
Weight (kg)						
SA (m²)						
ANC >1.5 (5 DAY EXP)	1.50	15.00	Day 1			
BILIRUBIN 1.5ULN	0.00	31.50	Day 1			
CREATININE(max 130)	0.00	130.00	Day 1			
PLATELETS > 50	50.00	600.00	Day 1			

Additional Prescribing Notes

PLEASE NOTE THAT LOMUSTINE IS A SINGLE DOSE ONLY.
The cycle length is defined as 28 days, however this will vary between patients. Defer appointments for patients requiring a 6 week cycle

Prescriber Notes: To be prescribed separately

1. Allopurinol 300mg once daily on days 1 to 5 of first cycle.

2. Consider gastro prophylaxis (proton pump inhibitor or H2- antagonist) for cover with dexamethasone.

Allocated by: _____

Date: _____

Confirmed by: _____

Date: _____

Authorised by: _____

Date: _____

Checked by: (Pharmacist) _____

Date: _____

Parenteral

Intrathecal

Oral

1

0

3

Forename	Surname		Protocol	DECC LYMPHOMA								SA (m²)		
			Course Name	DECC Lymphoma								Height (m)		
DOB	Patient NO		Local No.		NHS No								Weight (kg)	
Consultant			Ward		Diagnosis									
Address														

Record drug allergies or sensitivities

				Time	Date													
Drug & dose	LOMUSTINE																	
Actual dose	mg		Duration	ONE DAY														
Route	PO		Start Date															
Frequency	OD STAT		Start Day	1														
Quantity Dispensed		Dispensed by																
		Accuracy check																
Note	NB: PLEASE NOTE LOMUSTINE IS GIVEN FOR A SINGLE DOSE ONLY																	
Drug & dose	CHLORAMBUCIL																	
Actual dose	mg		Duration	4 DAYS														
Route	PO		Start Date															
Frequency	TDS		Start Day	1														
Quantity Dispensed		Dispensed by																
		Accuracy check																
Note																		

Allocated by:	Confirmed by:	Authorised by:	Checked by: (Pharmacist)	
Date:	Date:	Date:	Date:	

Forename		Surname		Protocol		DECC LYMPHOMA								SA (m²)	
				Course Name		DECC Lymphoma								Height (m)	
DOB		Patient NO		Local No.		NHS No								Weight (kg)	
				Ward											
Address															

Record drug allergies or sensitivities

				Time	Date													
Drug & dose		ETOPOSIDE																
Actual dose		mg		Duration		3 DAYS												
Route		PO		Start Date														
Frequency		OD		Start Day		1												
Quantity Dispensed				Dispensed by														
				Accuracy check														
Note		1 hr before food or on empty stomach																
Drug & dose		DEXAMETHASONE																
Actual dose		mg		Duration		5 DAYS												
Route		PO		Start Date														
Frequency		OD		Start Day		1												
Quantity Dispensed				Dispensed by														
				Accuracy check														
Note		Take in mornings; swallow whole with food																

Allocated by:		Confirmed by:		Authorised by:		Checked by: (Pharmacist)			
Date:		Date:		Date:		Date:		/ /	

Patient Details

Forename	Surname		Protocol	DECC LYMPHOMA					SA (m²)				
			Course Name	DECC Lymphoma					Height (m)				
DOB	Patient NO		Local No.		NHS No							Weight (kg)	
			Ward										
Address													

Record drug allergies or sensitivities

				Time	Date													
Drug & dose	ONDANSETRON																	
Actual dose	8 mg		Duration	5 DAYS														
Route	PO		Start Date															
Frequency	BD		Start Day	1														
Quantity Dispensed		Dispensed by																
		Accuracy check																
Note	If pre-pack supplied record Batch Number :_____.																	
Drug & dose	METOCLOPRAMIDE																	
Actual dose	10 mg		Duration	28 tablets														
Route	PO		Start Date															
Frequency	TDS+PRN		Start Day	1														
Quantity Dispensed		Dispensed by																
		Accuracy check																
Note	28 x Metoclopramide 10mg tablets are prescribed with each cycle, discuss with patient and delete if supply not required. If pre-pack supplied record Batch Number :_____.																	

Allocated by:	Confirmed by:	Authorised by:	Checked by: (Pharmacist)	
Date:	Date:	Date:	Date:	