Hospital Information (including name, address, telephone number)

Clinic information (including clinic name and telephone number)

Patient information (including name, address, date of birth, phone number)

Patient Name _____

Allergies (*also specify reaction*) ☐ None known

ETOP(PO) (etoposide)

Diagnosis: Breast Cancer

Cycle #: _____; Cycles repeat every 21 days

Height = _____ cm Weight = _____ kg

Body Surface Area (BSA) = _____ m^2

Clinical Verification

□ Bloodwork and other clinical parameters have been verified by a regulated health professional

_____ Date _____ Print name _____ Signature

□ Prescription has been verified by an nurse or pharmacist

_____ Date _____ Print name _____ Signature

Rx (Start Date/Day 1: _____)

etoposide 50 mg PO daily on an empty stomach on Days 1 to 14

Mitte: _____ x 50 mg capsules (ODB general benefit)

**Dose modification for: □ Age/performance status □ Renal function □ Hepatic function □ Hematologic toxicity*

□ *Other:* _____

Bloodwork to be done on (_____) Specify date(s)

NO Repeats

Supportive Care Rx

□ prochlorperazine 10 mg PO q6h PRN nausea

Mitte: _____ Repeat:_____

_____ Date _____ Print name _____ Physician Signature _____ CPSO#

Prescriber information (name, office phone number/fax, address if different than hospital address)
Pharmacist information (name, office phone number/fax)

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Action Cancer Ontario

OPTIONAL INFORMATION

□ Patient has been counseled by an Oncology Pharmacist

_____	_____	_____
Print name	Signature	Date

OR

□ Requires counseling
□ Drug interaction assessment

Drug-specific information

For the complete information, please refer to the Cancer Care Ontario drug information sheets available at www.cancercare.on.ca/drugformulary

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