

Hospital information (including name, address, telephone number)

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

Clinic information (including clinic name and telephone number)

Allergies (*also specify reaction*)

None known

Patient Name _____

IMAT (imatinib)

Diagnosis: Acute Lymphoblastic Leukemia (ALL)

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: _____)

imatinib 600 mg PO daily (standard dose) or

imatinib _____ mg PO daily*

Mitte: _____ x 100 mg tablets and/or _____ x 400 mg tablets EAP approved (if applicable)

*Dose modification for: Age/performance status Renal function Hepatic function Rash

Other _____

NO Repeats

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)

OPTIONAL INFORMATION

- Patient has been counseled by an Oncology Pharmacist

OR

_____	_____	_____
Print name	Signature	Date

- 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

SAMPLE