

## Treatment Guideline for OFF-PROTOCOL Chemotherapy Regimens

To be completed by the Consultant & authorised by Oncology Pharmacist BEFORE the start of treatment  
To be used if no Alliance protocol, or if a regimen is being used off-algorithm or outside Alliance-agreed indications

Patient's Name:  
(Hospital Sticker)

Indication / diagnosis:			
Drugs/dosage:			
Reference: (quote and attach source of information for this protocol in this indication)			
Specify why no currently available Network protocol is suitable:			
Administration details:			
Frequency:		Number of Cycles Intended:	
Radiotherapy: For chemo-radiation regimens, specify details of Radiotherapy			
Emetogenic Potential: (please tick)		<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low	
<b>Regular Investigations required (Please tick):</b>			
FBC <input type="checkbox"/>	Frequency:.....	LFT's <input type="checkbox"/>	Frequency:.....
U & E's <input type="checkbox"/>	Frequency:.....	Calc.Cr.Clearance <input type="checkbox"/>	Frequency:.....
Other <input type="checkbox"/> please specify	Test ..... Frequency:.....	EDTA <input type="checkbox"/>	Frequency:.....
Clinic appointments:	Frequency:		
Dose Modifications for toxicity:			
Comments/ additional drugs (e.g. folinic acid rescue):			
Consultant Name:		Consultant Signature:	
Date:		Date:	
Authorised by (Oncology Pharmacist) Name:		Signature:	
Date:		Date:	
One copy in the patient's Chemotherapy Folder		Filed by:	Date:
One copy to Lead/Senior Oncology Pharmacist, Pharmacy		Filed by:	Date:
For chemo-radiotherapy regimen, one copy to be put in patient's radiotherapy folder		Filed by:	Date: