**Beacon Oncology Treatment Plan Request Form**

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| **Requesting Provider:** |  |
| **Date Requested by:***When will the patient start?* |  |
| **Treatment Plan Name:** |  |
| **Disease State:** |  |
| **Reference:***If reference is attached, please only specify information below not found in reference.* |  |
| **Number of Cycles:** |  |
| **Duration of Cycles:** |  |
| **Outpatient or Inpatient?***If both, please specify inpatient days.* | ☐ Outpatient only ☐ Inpatient only ☐Both Outpatient and Inpatient Inpatient Days: |
| **Take home Medications:** |  |
| **Labs:** | ☐ CBCD Days:☐ CMP Days:☐ BMP Days:☐ Magnesium Days:☐ Phos Days: | ☐ Other: Days:☐ Other: Days:☐ Other: Days:☐ Other: Days:☐ Other: Days: |
| **Treatment Parameters:** |  |
| **Provider Specific Communication:** |  |
| **Nursing Specific Communication:** |  |
| **Hydrations (Pre and/or Post)***Fluid, volume, rate, duration, days of treatment* | **Pre:****Post:** |
| **Premedications***Name, dose, route, days of treatment* |  |
| **Chemotherapy***Name, dose, route, infusion time, days of treatment* |  |
| **Supportive care***Eg. growth factors, bicarbonate, PRN meds for inpatient)* |  |
| **Other Information for Builder:** |  |