

Oral Oncology Medication Patient Checklist

Patient Name: _____ DOB _____

Oral Medication _____ Diagnosis _____

Allergies: _____ Date Prescribed _____

Ordering Physician _____ Primary Nurse _____

Specialty Pharmacy _____

SP Phone _____ Fax: _____

- _____ Patient can swallow pills.
- _____ Patient understands that this is oral CHEMOTHERAPY.
- _____ Patient understands instructions in self administering oral chemotherapy.
- _____ Patient understands safe handling of oral chemotherapy.
- _____ Patient understands potential side effect of oral chemotherapy and when office should be notified of concerns .
- _____ Office contact information and after hours phone numbers have been given to patient
- _____ Patient has been advised to contact office if there are problems with prescription fulfillment.
- _____ Patient understands the IMPORTANCE of notifying office upon taking first dose.
- _____ Follow up doctor visits and lab visits were scheduled / discussed.

By my signature below, I attest that I have been taught about the oral chemotherapy that my doctor has prescribed for me. I understand the goal of this oral chemotherapy and that the success of this treatment weigh largely upon my compliance in taking the medication and informing my doctor of any issues that I may have. I understand that this prescription will be delivered to my home and it is imperative that I inform my doctor upon taking my first dose.

Patient signature _____

Notes: _____
