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:_____
_____