University Hospital Southampton
NHS Foundation Trust

INTRATHECAL CHEMOTHERAPY FORM

Below two boxes to be filled by the REFERRER

Patient details	
Surname	Referring hospital
First name	Department
Date of Birth	Email address
Hospital number	Bleep/contact number
NHS number	
Postal address	

Patient's condition

Current chemotherapy

Intrathecal chemotherapy type, dose and frequency

Date required/Week starting

Patient on any anticoagulants/antiplatelets
(advice regarding anticoagulation/antiplatelet therapy is the responsibility of the referrer)

Patient's platelet count if known with date

Do they require platelet transfusion prior and whether that has been arranged

Please email this document now to ITchemo@uhs.nhs.uk

Below table to be filled by the IT lead SpR

IT prescriber (Please prescribe at least IT chemo 48 hours before the procedure to give ample time for pharmacy to make the chemotherapy)

IT Operator	Bleep/contact details	
IT nurse available	Planned Date	Time

Please email this document now to Haematologytreatmentschedulers@uhs.nhs.uk ; C7sisters@uhs.nhs.uk and Oncologypharmacy@uhs.nhs.uk as well as to the referrer

Haematology Treatment Schedulers – Please book the patient and inform the patient via telephone.
Please print this form once the booking is complete.

IT CHEMOTHERAPY PROCEDURE

Date and Time

Platelet count

Coagulation profile

Written consent

Procedure details

Aftercare advice given

Next IT chemo date (or please comment if needs to be rescheduled by the referrer)