NEW ENGLAND
Cancer Specialists
Infusion Center
Kennebunk · Portsmouth · Scarborough · Topsham
Phone: 207-303-3225 Fax:207-692-2473

Methotrexate

Patient Name:_____ **DOB:**_____

Diagnosis: _____ Diagnosis Code:_____

Height: _____(cm) Actual Weight: ____(kg) Allergies: _____

Required labs:

CBC _____

CMP _____

HCG _____

Additional labs/orders_____

_____

Protocol/Regimen:

Methotrexate 1 mg/kg IM x _____ kg _____mg on days _____

_____ every _____

***In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: _____

Provider Signature: _____ Date: _____

Phone: _____ Fax: _____ Pager: _____