

Oral Chemotherapy

Patient Education Guide

Place Copy In Chart

Oral Chemotherapy

Enhancing Adherence and Knowledge

Patient Name: _____ DOB: _____

1. IDENTIFY LEARNING BARRIERS

- None
 Language Literacy Hearing Vision Problems Color Blindness Cognitive Impairment
 Motor Skills Motivation Religious Dietary Age Feeding Tube
 Emotional (Depression/Anxiety)

2. KEY ASSESSMENT QUESTIONS

- 1) What has the patient been told about their treatment plan with oral medications? Yes
No *Verify that the patient knows these oral agents are for their cancer and are taken by mouth.*
- 2) What other medications or pills does the patient take by mouth? Yes
No *document on patient medication reconciliation sheet*
- 3) Is patient able to swallow pills or tablets? If no explain. Yes No
- 4) Is patient able to read the drug label/information? Yes
No
- 5) Is patient able to open their medicine bottles or packages? Yes
No
- 6) Are you taking other pills for your cancer? Yes
Is patient taking the medications or experiencing adverse drug effects.
- 7) Is patient having trouble keeping down the pills? *Ask for nausea or vomiting.* Yes No
- 8) Did patient fill prescription? *If not. what problems are they having?* Yes No
- 9) Are there insurance issues that interfere with obtaining oral chemo medications? Yes
No
- 10) Does patient have problems affording/paying for the chemo drug? Yes
No

3. EDUCATION EVALUATION

Learning was evaluated by having patient answer the following questions to ensure understanding of information/key points:

- What is the name of your cancer pill-tablet?
- When will you take your cancer pill-tablet?
- Does it matter if you take this pill-tablet with food or not?
- Where do you plan to keep the pills-tablets
- When should you call the Doctor or Nurse?
- Do you have any other questions?
- Your next appointment is?

Did patient answer all question correctly? Yes No

Verbalized full understanding? Yes No

RN Signature: _____ Date: _____

Time: _____

ORAL CEMOTHERAPY

PATIENT EDUCATION GUIDE

FOR SELF-ADMINISTRATION (Patient Receives COPY)

The following items were discussed with the patient and family member/friend (if applicable)

RED requires completion by RN

- 1) Inform any other doctors, dentists or healthcare providers that you are taking tablets for your cancer. The **generic name** of this **oral drug** is _____ and the **trade name** is _____.
- 2) Keep the tablets away from children and pets. Store the container with the labels at room temperature, away from heat, sunlight, or moisture, as it may degrade the tablets, potentially making them less effective.
- 3) Keep the tablets in the original container, unless otherwise directed. It could be dangerous to mix with other pills.
- 4) Wash your hands well with soap and water before and after handling the tablets.
- 5) If you are not able to swallow the tablet it can be placed in about 4 ounces of water to soften or break the tablet, stir until the tablet is not seen anymore and drink right away. Then rinse the sides of the container with a little more water and drink to make sure that you got the entire dose. Wash the glass well, rinse twice.
- 6) The tablet should be taken on an **empty** **full stomach** _____ hour before or _____ hours after a meal or any time, at approximately the same time each day (_____ a day). Take with a large glass of water.
- 7) Have a system to make sure you take your tablets correctly. (Ideas: timer, clock, cell phone, calendar or other reminders)
- 8) If you miss a dose. Take it as soon as possible.
However, if it is almost time for your next dose (due in less than 4 hours), skip the missed dose and go on to your regular dosing schedule. **Do not** double dose.
- 9) If you vomit after taking the pill, do not repeat the dose. Take the drug at the next scheduled time/day.
- 10) If you accidentally take too many tablets or if someone else takes your tablets, contact your physician immediately.
- 11) Normally, you will not have extra or out-dated medication. but if you do, return it to your doctor for disposal. Do not throw the left over medication in the garbage.
- 12) Carry with you a list of medicines that you are taking at all times and update it as changes occur, including your chemotherapy drugs.
- 13) Let us know if you have a problem with paying for or getting your chemotherapy medication.
- 14) Plan ahead for travel, refills and weekends.
- 15) You can continue on the medication, per your doctor as long as you are tolerating it and it is helping your cancer.
- 16) Avoid pregnancy and breast feeding unless otherwise instructed.
- 17) These medications can interfere with many drugs, which may change how they work in your body. Talk with your doctor before starting any new drugs, including over-the-counter medicines, natural products, herbals or vitamins.
Known Drug interactions: _____
- 18) Your doctor may ask you to maintain a drug log if you are having difficulty or frequent symptoms. Bring drug log to the next clinic visit for review.
- 19) Your Oncology Doctor is Dr. Kelly Young. **Office telephone number is 913-** _____ - _____
- 20) We reviewed the provided patient education information about your oral medication with you, copy provided to take home.
- 21) We reviewed **specific drug side effects:** _____
- 22) We reviewed serious **side effects to report immediately:** _____
- 23) Involved family and/or caregivers included in the education described above: N/A Yes No
- 24) Frequency of Office Visits: _____
- 25) Frequency of Monitoring: _____
- 26) Date to STOP medication: NA, _____

Patient Signature: _____ Date: _____ Time: _____

RN Signature: _____ Date: _____ Time: _____