ONCOLOGY PATIENT INFORMATION SYSTEM (OPIS) NURSE TIP SHEET

*Please refer to the OPIS eManual for more detailed instructions.

LOGGING ON

1. **Double click** on the **OPIS Icon.**
2. Enter your **ID** and **signature.**
3. Click the "**OK**" button to proceed.

CHANGING YOUR SIGNATURE (PASSWORD)

Change your default password the first time you login to OPIS to something secure and private. It is **highly recommended** that you change your password **every 90 days**.

1. Select the **User Options** menu and then **Signature/Pin.**
2. Type your **Old Signature** (provided by the Help Desk).
3. Type your **New Signature.**
4. **Verify** (retype) your **New Signature.**
5. Click the **Save** button on the toolbar.

Signatures must be 8-10 characters long and should contain 3 of these 4 characteristics:

- Uppercase letters (A - Z)
- Lowercase letters (a - z)
- Numeric characters (0 - 9)
- Non-Alpha numeric characters (!,#,$, etc.)

HELP

OPIS eManual: Provides step-by-step assistance to OPIS users on OPIS functionality.

To access this manual, **click** on the **Internet Explorer** icon on any UHN computer to access the Corporate Intranet, select **Education > DIGITAL Education > eManuals > OPIS eManual**.

Once in the eManual, **select** a topic from the **Table of Contents** *or* **click** on **Index** to search topics alphabetically or by keyword.

Technical Issues: Call **H-E-L-P** (4357) from any phone at UHN or (416) 340-4800x4357. The Customer Care Centre is available 24 hours a day, 7 days a week.

PRINTER OPTIONS / PRINTING

To setup your printer at your local workstation (if applicable):

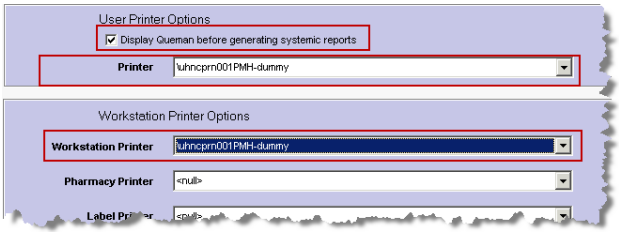
From the menu select **User Options** > **Printer Options**

Workstation Printer:

- This is the printer this particular PC is printing to (not user specific).
- Select the printer closest to you, using the Floor_Room # naming convention.
- If the printer you want to setup is not on the list, call the Customer Care Centre at extension 4357 to setup a new print queue.

Printer:
setup the same as the Workstation Printer.

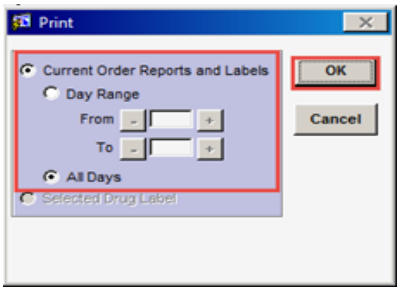
The remaining printers setup: leave as <NULL>.



To print a regimen order, locate and **open the order** you want to print, **click** the **Print** icon on the toolbar.

In the **Print window**, select **All Days** and click **OK** to ensure you print all days of the order.

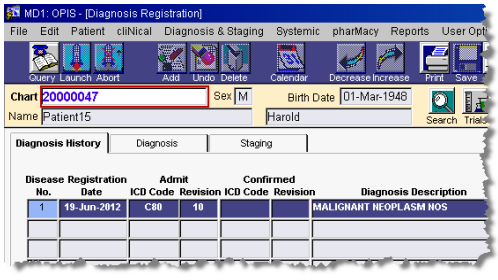
Clicking the **Cancel** button will cancel all reports .
Note: please see the **OPIS eManual** for a more detailed description of using the Print window.



In the Reports Submission window, **click** on the **PMH Pharmacy Copy (CDC)** report, **click** on the **Printer** tab, **enter** the **number of copies**, then **click Submit**.

PATIENT SEARCH

1. Open the specific menu within OPIS that you wish to work in (e.g. Diagnosis, Chemo Orders, etc.).
2. **Type** the patient's **MRN** number in the **Chart** field.
3. **Press** the **Enter** key (Patient demographic information and patient details for that area will populate).



Alternatively, use the **Search icon to search for the patient by Name.*

ENTERING A CLINICAL NOTE

Clinical Notes are used by clinicians to communicate information about the patient. Notes are "write-protected" and cannot be deleted. A note can be deactivated if it is no longer relevant or was entered on the wrong patient.

In OPIS, Clinical Notes should be used by nurses to document details such as taking a verbal or telephone order to adjust medication doses, document details around stopping and/or restarting IV medications, and any other information that needs to be communicated about the patient.

1. **Select Clinical Information > Clinical Notes.**
2. **Search** for the **patient**.
3. **Click** in a **blank** row ***or*** **click** on the **Add** button on the Toolbar.
4. **Click** on the **Full Note Text** button to open a larger window in which to type.
5. **Type** the note information using the format adopted at PMH:
   Protocol Name
   Note details
   Name, Designation, & Contact Info
6. **Select** a **remind** option for **Order Entry** and **Medication Admin**. These settings control whether the note will pop up during Order Entry or Documentation of Meds in OPIS.
7. **Click** the **Save** button on the toolbar. 

To Deactivate a Note:

1. **Select Clinical Information >Clinical Notes.**
2. **Search** for the **patient**.
3. **Click** on the **Note** that should be deactivated.
4. **Click** on the **Delete** button on the toolbar.
5. **Click** the **Yes** button on the message to confirm you wish to delete the note.
6. **Click** the **OK** button on the message confirming the record has been flagged as deleted.
7. **Click** the **Save** button on the toolbar.

The note text will appear in gray to indicate that it has been deactivated but it will still be visible (similar to paper documentation that has been stroked out and initialed).

REVIEWING REGIMEN ORDERS

1. **Select Systemic Therapy > Chemo Order History.**
2. **Search** for the patient (see PATIENT SEARCH).
3. Review outstanding regimen orders for the patient from the **Order History** tab. **Select** the **order** in Order History that you want to review (most recent orders appear at the top of the list). Click the **View** button. 

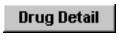
4. **Click** on the **Chemo Order** tab to review the high level details of the order. Mandatory fields have bolded field labels.
5. The **Height** and **Weight** of the patient at the time the order was entered displays in the Body Surface Area section.
6. **Click** in the **Chemo** field and then click on the **Reg Detail** button. 

7. Within the Reg Detail window, **click** the **Regimen Notes** button 

. **Regimen Notes** will display important information that is specific to the regimen including information that will be used to clear the patient for treatment (unless the orderer places an overriding comment in the Comment field of the Chemo Order), study information for Clinical Trial Regimens, and administration specific information.
8. After closing the Regimen Notes window and the Reg Details window, and returning to the Chemo Order tab, you may **click** on the **Add/View** button 

to see any additional comments that have been entered on the order, or the **All Comm/Notes** button 

to see all Clinical Notes as well as all Order Comments.
9. You may also wish to **click** on the **View Changes** button 

to see what recent changes have been made to the order.
10. Click on the **Order Details** tab. You can see all the medications that make up the regimen order here. A **colour legend** at the bottom identifies the meaning of the highlighted columns, rows, and cells within the order. **Note:** some colour highlighting is **not in use** at Princess Margaret: yellow for Allergy/Potential Allergy ,the purple highlighting for the Patient Not Treated, blue for volume check, purple for concentration check.
11. To view an individual medication's full details, **click** on the **medication** in the list and then **click** on the **Drug Detail** button 

. Administration instructions appear in the **Pharm Sig** box within this window.
12. The **Reg Notes** button 

at the bottom of this screen will provide the same information as the Regimen Notes button within the Reg Details window.
13. The **View Changes** button 

can also be accessed at the bottom of this screen.
14. When finished reviewing the order, you can **click** on the **Order History** button to select another order to view, or follow the steps in the **PATIENT SEARCH** section of this document to change to a different patient.

DOSE ADJUST

1. On the **Order Detail** tab of the order, **click** on the **medication** you wish to dose adjust. *Use **CTRL+Click** method to select multiple medications if they can be adjusted in the same way.*
2. **Click** on the **Dose Adjust** button**.**
3. **Select** a **Change Reason** from the **List of Value** options.
4. In the **Change dose as follows** section, **select** whether the change is **permanent** (applies to repeat orders) ***or*** is **temporary** (does not apply to repeat orders).
5. **Select** an **option** indicating **how the dose should be changed** (e.g. previous ordered dose, use the ideal dose, specific dose value, percentage of current or original dose, etc.).
6. In the **Apply to which drugs** section, **select** an appropriate **option** (e.g. selected drug(s) only, all occurrences of the select drug(s), etc.).
7. **Click** the **Preview** button. **Note:** Changes will not be applied to selected medications that have already been verified by pharmacy. However, if you selected the ***permanent*** change option, you will be asked if you *wish to apply the change to all days the next time you re-order*.
8. If the change appears as you intended, **click** the **Apply** button.
9. Once all adjustments are made to the order, **click** the **Sign Order** button, **enter** your **signature**.
10. In the **Print window**, select **an appropriate option** and **click OK** (or click Cancel if no reports are needed).
11. Select any reports to be printed, check the number of copies on the Print tab and click **Submit**.

ADD MEDICATIONS

Add

1. On the **Order Detail** tab of the order, **click** on the medication **before or after** in the sequence where you want to add the new medication.
2. **Click** the **Add** button.
3. **Click** on the appropriate **option** to place the order *above or below* the current record and then **click OK**.
4. In the **Current Drug Detail** window, complete all the **mandatory** fields (**bolded field labels**). **Note:** When adding **Take Home** medications change **Patient/Adm. Type** to **Take Home** and ensure all relevant information is entered (e.g. duration, refills & quantity – if applicable, and Pharm Sig. instructions, etc.).
5. **Click** the **Close** button to close the Current Drug Detail window.
6. Once all adjustments are made to the order, click the **Sign Order** button, enter your **signature** and **click OK**.
7. In the **Print window**, select **an appropriate option** and **click OK** (or click Cancel if no reports are needed).
8. Select any reports to be printed, check the number of copies on the Print tab and click **Submit**.

MOVE/COPY MEDICATIONS

Move Copy

1. On the **Order Detail** tab of the order, **click** on the **medication** you wish to **move *or* copy**.
2. **Click** the **Move** button *if moving a medication in the sequence*, or the **Copy** button *if copying a medication within the sequence*.
3. In the **Copy *or* Move** window, **enter** a **number** in the **After record** field indicating which record it should follow in the current sequence.
4. **Click** in the **Treatment Day** field and update the number to the appropriate Treatment Day (e.g. Day 1, 8, 15, etc.).
5. **Click** in the **Treatment Date** field and it will automatically update to match the Treatment Day entered.
6. **Click** the **OK** button.
7. Once all adjustments are made to the order, **click** the **Sign Order** button, **enter** your **signature** and **click OK**.
8. In the **Print window**, select **an appropriate option** and **click OK** (or click Cancel if no reports are needed).
9. Select any reports to be printed, check the number of copies on the Print tab and click **Submit.**

DATE ADJUST

Date Adjust

Use the Date Adjust button to reschedule an entire order or specific medication days.

1. **Select Systemic Therapy > Chemo Order History**.
2. **Search** for the **Patient**.
3. **Select** the **order** you wish to reschedule and **click** the **View** button.
4. On the **Order Details** tab, **click** the **Date Adjust** button.
5. **Select** a **Change Reason** from the **List of Value** options.

To Date Adjust the entire order:

6. Follow the steps 1-5 above and then, in the **Apply To** area, **select** the option for **Entire Order**.
7. In the **Set Date To** area, **click** on the **calendar** and **select** the **new date** for the order.
8. **Click** the **Preview** button and then the **Apply** button.
9. **Click** the **Sign Order** button and enter your **signature**.
10. In the **Print window**, select **an appropriate option** and **click OK** (or click Cancel if no reports are needed).
11. Select any reports to be printed, check the number of copies on the Print tab and click **Submit.**

To Date Adjust specific medication days:

6. Follow the steps 1-5 for DATE ADJUST and then, in the **Apply To** area, **select** the option for **Day Range**.
7. In the **From** field enter the **initial treatment Day** number of the medications to be rescheduled.
8. In the **To** field enter the **last treatment Day** number of the medications to be rescheduled.
9. In the **Set Date To** area, click on the **calendar** and **select** the **new date** for the **initial treatment Day** (of the days you are rescheduling).
10. **Click** the **Preview** button and then **Apply**. **Note:** all days being rescheduled will update following the original intervals between treatment days.
11. **Click** the **Sign Order** button, **enter** your **signature** and **click OK**.
12. In the **Print window**, select **an appropriate option** and **click OK** (or click Cancel if no reports are needed).
13. Select any reports to be printed, check the number of copies on the Print tab and click **Submit.**

MEDICATION ADMIN

The Medication Admin area is used to both review and document administration information in OPIS. UHN is only reimbursed by CCO for medications documented in OPIS.

Treatment Search:

1. **Select Systemic Therapy > Medication Admin**.
2. If the treatment search window does not open automatically, **click** on the **Search**  icon on the toolbar.
3. **Enter** Treatment Search parameters to search **by treatment date**, **patient *or* physician** and then **click** the **Find** button. **Note:** You can refine your search using the status filters and sorting options.
4. **Select** the **treatment date/regimen of the appropriate patient** and then **click OK**. The treatment screen will open.

Reviewing MAR documentation:

5. After following the steps 1-4 in Treatment Search to open a treatment, high level details of the treatment appear on the **Treatment** tab (e.g. diagnosis, physician abbreviation, regimen name, comments, height/weight/BSA, etc.)**.**
6. **Click** on the **Details** tab and **review** any **Clinical Notes** that pop up using the arrow keys to navigate through them.
7. Only **Outpatient** (O) medications that have been administered in the Chemo Day Care and Transfusion Centre are documented in OPIS and will display a **checkmark** once documented.
8. **Click** on **each of these medications** and the corresponding **MAR information appears on the right side** of the screen indicating Admin Start Time, End Time (for Clinical Trial regimens), Pharm Sig. instructions, name of administering RN, etc.
9. **Click** the **Search** icon to search for another treatment, ***or*** **click** the **Exit** button to leave Medication Admin.

Documenting a Treatment:

5. Follow the steps 1-4 above in **Treatment Search**, to open the treatment you wish to document.
6. **Click** on the **Details** tab and **review** any **Clinical Notes** that pop up using the arrow keys to navigate through them.
7. **Click** on the **first medication** in the treatment to display the administration information in the Current Drug window on the right. **Click** on the **down arrow key** on your keyboard to move to the next medication. Once you have reviewed all the

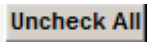
medications in the treatment, you are ready to start documenting. Only **Outpatient** (O) medications that have been administered in the Chemo Day Care and Transfusion Centre are documented in OPIS and will display a **checkmark** once documented. Medications to be administered in the Chemo Day Care or Transfusion Centre should be verified by Pharmacy before you begin documenting administration. Medications sequence numbers still highlighted in light blue have not been verified by Pharmacy.

8. **Click** the **Admin checkbox** next to the **medication** you wish to document.
9. Enter the **Adm Start Time**.
10. Enter the **End Time** (required for clinical trial regimens).
11. **Note:** If necessary, an administration comment may be entered in the **Nurse Comment** area by clicking the **Add/View** button 

. **Remember** to enter a **Clinical Note** (Clinical Information > Clinical Notes) if the dose has been zeroed, or if there is some information that the physician should be reminded of for the next order.
12. **Click** the **Save** button on the toolbar. **Note:** medications with linked bag codes will automatically update with the same information. Medications will appear with green highlighting once administration information is saved.
13. Follow the steps 8-12 above to document additional medications in the treatment.

Un-documenting a Medication or Treatment:

5. Follow the steps 1-4 above in **Treatment Search**, to open the treatment you wish to un-document (mark as un-administered).
6. **Click** on the **Details** tab and **review** any **Clinical Notes** that pop up using the arrow keys to navigate through them.
7. **Uncheck** the **Admin checkbox** next to the **medication** you wish to **un-document.**
8. **Select** a **reason** for un-documenting (e.g. wrong drug, wrong patient, etc.).
9. **Click the Save button on the toolbar.**
10. Repeat steps 6-9 for any additional drugs to be un-documented.



Note: if the entire treatment should be un-documented, use the **Uncheck All** button, enter a **reason** for un-documenting , and click **Save**.

REVIEWING VITAL SIGNS AND ACCESS DEVICE DOCUMENTATION

Vital Sign and Access Device documentation is captured in the Medication Admin area in OPIS.

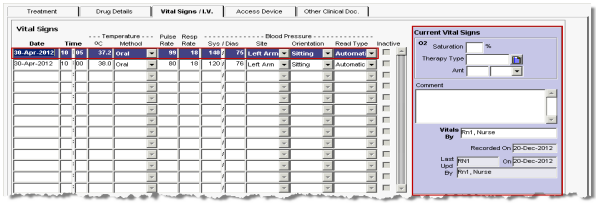
Treatment Search:

1. **Select Systemic Therapy > Medication Admin**.
2. If the treatment search window does not open automatically, **click** on the **Search**  icon on the toolbar.
3. **Enter** Treatment Search parameters to search **by treatment date**, **patient *or* physician** and then **click** the **Find** button. **Note:** You can refine your search using the status filters and sorting options.
4. **Select** the **treatment date/regimen of the appropriate patient** and then **click OK**. The treatment screen will open. *At least **one medication** must be documented as administered in the treatment in order for Vital Signs or Access Devices to be documented for the treatment*.

Reviewing Vital Sign documentation:

5. After following the steps 1-4 above to open a treatment. High level details of the treatment appear on the **Treatment** tab (e.g. diagnosis, physician abbreviation, regimen name, comments, height/weight/BSA, etc.)**.**

6. **Click** on the **Vital Signs/I.V.** tab and **review** any **Clinical Notes** that pop up using the arrow keys to navigate through them.
7. Documented **Vitals Signs** appear at the top of this tab.

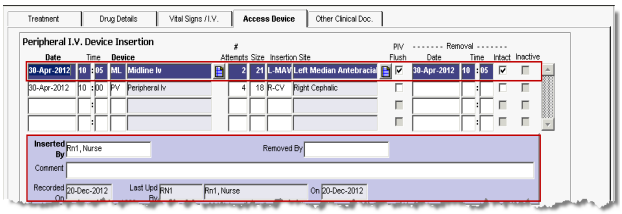


Notes:

- Multiple Vital Signs may be documented for the same treatment.
- I.V. Therapy is not being documented in OPIS at this time.

Reviewing Access Device documentation:

5. After following the steps 1-4 above to open a treatment, high level details of the treatment appear on the **Treatment** tab (e.g. diagnosis, physician abbreviation, regimen name, comments, height/weight/BSA, etc.)**.**
6. **Click** on the **Access Device** tab and **review** any **Clinical Notes** that pop up using the arrow keys to navigate through them.
7. Documented **Peripheral** and **Midline IVs** insertion/access appears at the top of this tab.



8. Documented **Central Venous Access Device** access appears in the middle of the screen on the Access Device tab.

Notes:

- The **Alternate Access Device** section and **Other Clinical Doc.** tab are not currently in use at PMH.
- Multiple Peripheral IV and Midline IV insertion/access per treatment may be documented
- Currently one CVAD access per treatment may be documented.

DOCUMENTING VITAL SIGNS

Vital Sign documentation is entered in the Medication Admin area in OPIS.

Treatment Search:

1. **Select Systemic Therapy > Medication Admin**.
2. If the treatment search window does not open automatically, **click** on the **Search**  icon on the toolbar.
3. **Enter** Treatment Search parameters to search **by treatment date**, **patient *or* physician** and then **click** the **Find** button. **Note:** You can refine your search using the status filters and sorting options.
4. **Select** the **treatment date/regimen of the appropriate patient** and then **click OK**. The treatment screen will open.

Documenting Vital Signs:

5. Follow the steps 1-4 in **Treatment Search** to open the treatment for which you need to document vital signs. *At least **one medication** must be documented as administered in the treatment in order for Vital Signs or Access Devices to be documented for the treatment*.
6. **Click** on the **Vital Signs/I.V.** tab of the treatment.
7. The **date field** will be defaulted to the date of the scheduled treatment. **Click** in the **Time** field and **enter** the time Vital Signs were taken**.**
8. **Click** in the **Temperature (**field and **ente**r the patient's temperature.
9. **Click** on the **drop down arrow** to select the Temperature method.
10. **Click** in the **Pulse Rate** field and **enter** the patient's pulse rate.
11. **Click** in the **Resp Rate** field **and enter** the patient's respirations.
12. **Click** in the **Sys** field and **enter** the patient's systolic blood pressure.
13. **Click** in the **Dias** field and **enter** the patient's diastolic blood pressure.
14. **Click** on the **drop down arrow** to select the Blood Pressure site.
15. **Click** on the **drop down arrow** to select the Blood Pressure Orientation.
16. **Click** on the **drop down arrow** to select the Blood Pressure Read Type.
17. If **O2 Saturation** is also being documented, **click** in the **Sat** field and enter the O2 Saturation.
18. **Click** on the **LOV** button  to select O2 Therapy Type.
19. **Click** in the **Amt** field and **enter** the **amount** and then **click** the **drop down arrow** to **select** litres or %.
20. **Click** the **Save** button  on the toolbar**.**

Inactivate Vital Sign Documentation:

5. Follow the steps 1-4 in **Treatment Search** to open the treatment for which you need to document vital signs.
6. **Click** on the **Vital Signs/I.V.** tab of the treatment.
7. **Click** on the **row** of the Vital Sign documentation you wish to inactivate.
8. **Click** the **Delete** button  on the toolbar.
9. **Click Yes** on the Message "Are you sure you to deactivate this record?"
10. **Select** and **Inactive Reason** and **click OK**.

DOCUMENTING ACCESS DEVICE INFO

Access Device documentation is entered in the Medication Admin area in OPIS.

Treatment Search:

1. **Select Systemic Therapy > Medication Admin**.
2. If the treatment search window does not open automatically, **click** on the **Search**  icon on the toolbar.
3. **Enter** Treatment Search parameters to search **by treatment date**, **patient *or* physician** and then **click** the **Find** button. **Note:** You can refine your search using the status filters and sorting options.
4. **Select** the **treatment date/regimen of the appropriate patient** and then **click OK**. The treatment screen will open.

Documenting Peripheral IV and Midline IV Device Insertion/ Access

5. Follow the steps 1-4 in **Treatment Search** to open the treatment for which you need to document vital signs. *At least **one medication** must be documented as administered in the treatment in order for Vital Signs or Access Devices to be documented for the treatment*.
6. **Click** on the **Access Device tab** of the treatment.
7. The **date field** in the **Peripheral I.V. Device Insertion** section will be defaulted to the date of the scheduled treatment. **Click** in the **Time** field and **enter** the time the device was inserted or accessed**.**
8. **Click** the **LOV**  button next to the **Device** field and **select** the **type of device**.
9. **Click** in the **Attempts** field and **enter** the **number of attempts**.
10. **Click** in the **Size** field and **enter** the **size of the catheter** used.
11. **Click** the **LOV**  button next to the **Insertion Site** field and **select** the **Insertion Site**.
12. For midline IV access, **click** the **PIV Flush checkbox** if the device was flushed.
13. **Click** in the **Comment** field and enter any details such as the date/time of the flush and any other relevant information.
14. **Click** the **Save**  button on the toolbar.

Documenting CVAD Device Insertion/Access

5. Follow the steps 1-4 in **Treatment Search** to open the treatment for which you need to document vital signs. *At least **one medication** must be documented as administered in the treatment in order for Vital Signs or Access Devices to be documented for the treatment*.
6. **Click** on the **Access Device tab** of the treatment.
7. The **date field** in the **Central Venous Access Device** section will be defaulted to the date of the scheduled treatment. **Click** in the **Time** field and **enter** the time the device was inserted or accessed**.**
8. **Click** the **LOV**  button next to the **Device** field and **select** the **type of device**.
9. **Click** in the **Attempts** field and **enter** the **number of attempts**.
10. **Click** in the **Size** field and **enter** the **size of the needle** used.
11. **Click** in the **Length** field and **enter** the **length of the needle** used.
12. f the dressing was changed, **click** the **Dressing Change checkbox**.
13. In the dressing change section, **click** in the **Date** field and enter the **date the dressing was changed**.
14. **Click** in the **Time** field and enter **the time the dressing was changed**.
15. If the device was flushed and/or locked, **you must document this in the Comment field. Click** in the **Comment** field and enter the details (e.g. After treatment port was flushed and locked with 3ml of Heparin as per medical directive.)
16. **Click** the **Save**  button on the toolbar.

Inactivate Access Device Documentation:

5. Follow the steps 1-4 in **Treatment Search** to open the treatment for which you need to document vital signs.

5. **Click** on the **Access Device tab** of the treatment.
6. **Click** on the appropriate **row** of the Peripheral I.V. Insertion Device documentation ***or*** on the Central Venous Access Device documentation you wish to inactivate.
7. **Click** the **Delete** button  on the toolbar.
8. **Click Yes** on the Message "Are you sure you to deactivate this record?"
9. **Select** and **Inactive Reason** and **click OK**.
10. **Click** the **Save** button on the toolbar. The documentation is visible but a checkmark appears in the **Inactive** column.

MED SUMMARY

The Med Summary tabs display regimens/treatments for the patient that have been ordered in OPIS as well as the administration information documented in OPIS.

Select Systemic Therapy > Med Summary.

Regimen	Displays a list of regimens that have been ordered for the patient.
Medication Received	**Select** a **regimen** on the first tab, then **click** on the **Medication Received** tab to see a summary view of the listed medications' ordered dose, given dose, and intensity (percentage received to date).
Matrix	**Select** a **regimen** on the first tab, then **click** on the **Matrix** tab to see the medication information broken into individual treatment days. Given doses will be highlighted in Green.
All Treatments	**Click** on the **All Treatments** tab to see a list of all the scheduled treatment dates for the patient. Treatments highlighted in Green have been fully administered and treatments highlighted in Gold have been partially administered.
All Drugs	**Click** on the **All Drugs** tab to see each scheduled medication and the associated Administration information.

NOTES:

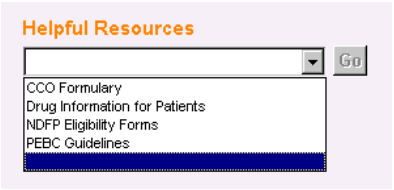
CCO RESOURCE LINKS

Cancer Care Ontario provides several links within OPIS to information on their website.

On Main Menu

Helpful Resources provides links to:

- CCO Formulary
- Drug Information for Patients
- New Drug Funding Program Eligibility Forms
- Program Evidence-Based Care Guidelines



On various Function Screens

- The buttons are active if there is a valid link to a Provincial Regimen and there is content to display
- There will not be content for Clinical Trial Regimens

Regimen Specific (applies to the selected regimen)		
Reg Monograph	Monograph for the regimen	Located in Chemo Order Entry, Medication Admin, Regimen Specification
PEBC	Program Evidence-Based Care information	Located in Chemo Order Entry, Medication Admin, Regimen Specification
Description	Short provincial formulary regimen description	Located Regimen Specification
Drug Specific (applies to the selected drug)		
Drug Monograph	Drug monograph	Located in Chemo Order Entry, Medication Admin, Regimen Specification
Patient Drug Info ENG	Information about the drug for the patient (English)	Located in Chemo Order Entry, Medication Admin, Regimen Specification
Patient Drug Info FR	Information about the drug for the patient (French)	Located in Chemo Order Entry, Medication Admin, Regimen Specification
FDB Monograph	First Databank Drug Monograph	Located in Chemo Order Entry, Medication Admin, Regimen Specification