

## Patient information

Patient name \_\_\_\_\_

DOB \_\_\_\_\_

Mobile number \_\_\_\_\_

Weight \_\_\_\_\_  kgs  lbs

Diagnosis  Malignant neoplasm of the female breast  
 Other \_\_\_\_\_

Allergies  NKDA  \_\_\_\_\_

## Medication instructions

Pre-medications  N/A  
 Provider prescribed: \_\_\_\_\_

Medication order Dose Frequency  
 Initial dose: 1,200 mg pertuzumab, 600 mg trastuzumab, 300,000 units hyaluronidase. followed by 600 mg pertuzumab, 600 mg trastuzumab, and 20,00 units hyaluronidase  Initial, then every 3 weeks  
 Other \_\_\_\_\_

Medication route  Subcutaneous injection  
 Other \_\_\_\_\_

Lab order (Include frequency) Please list any labs to be drawn by the infusion clinic:  
 N/A  
 \_\_\_\_\_

Prerequisites Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Documentation of which combined therapy patient is currently on

Please send to  Columbia, MD  Silver Spring, MD  Bowie, MD  Frederick, MD

## Referring provider information

Referring provider name \_\_\_\_\_ NPI \_\_\_\_\_

Practice name \_\_\_\_\_

Point of contact Name \_\_\_\_\_ Email \_\_\_\_\_ Phone \_\_\_\_\_

Provider signature \_\_\_\_\_ Date \_\_\_\_\_