SPRINGSIDE INFUSION

Sandostatin LAR Depot

Patient information

Patient name _____ **DOB** _____

Mobile number _____ **Weight** _____ ☐ kgs ☐ lbs

Diagnosis

☐ Acromegaly, ICD 1 0: e22.0
☐ Severe diarrhea/flushing episodes associated with metastatic carcinoid tumors, ICD 10: e34.0
☐ Profuse watery diarrhea associated with vasoactive intestinal peptide (vip) secreting tumors, ICD 10: e16.8
☐ Other _____

Allergies ☐ NKDA ☐ _____

Medication instructions

Pre-medications

☐ N/A
☐ Provider prescribed: _____

Medication order

Dose

☐ Patients not currently receiving sandostatin injection: acromegaly: 50 mcg three times daily sandostatin injection subcutaneously for 2 weeks followed by sandostatin lar depot 20 mg intragluteally every 4 weeks for 3
☐ Patients not currently receiving sandostatin injection: : carcinoid tumors and vipomas: sandostatin injection subcutaneously 100 to 600 mcg/day in 2-4 divided doses for 2 weeks followed by sandostatin lar depot 20 mg every 4 weeks for 2 months
☐ Patients currently receiving sandostatin injection: : acromegaly: 20 mg every 4 weeks for 3 months
☐ Patients currently receiving sandostatin injection: : carcinoid tumors and vipomas: 20 mg every 4 weeks for 2 months
☐ Patients currently receiving sandostatin injection: : renal impairment, patients on dialysis: 10 mg every 4 weeks
☐ Patients not currently receiving sandostatin injection: hepatic impairment, patients with cirrhosis: 10 mg every 4 weeks
☐ Other _____

Frequency

N/A
☐ Other _____

Medication route

☐ Subq
☐ 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

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

Referring provider information

Sandostatin LAR Depot

Referring provider name _____ **NPI** _____

Practice name _____

Point of contact Name _____ Email _____ Phone _____

Provider signature _____ Date _____