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

© Springside Infusion, Inc.

Referring provider name ____ **NPI** ____________________

Practice name ____

Point of contact Name __________________ Email __________________ Phone __________________

Provider signature ____ Date ________________

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