SPRINGSIDE
INFUSION

Tepezza

Patient information

Patient name ________________________________ **DOB** ______________________

Mobile number ______________________________ **Weight** ____________ ☐ kgs ☐ lbs

Diagnosis N/A
☐ Other ____

Allergies ☐ NKDA ☐ ____

Medication instructions

Pre-medications ☐ N/A
☐ Provider prescribed: ____

Medication order

Dose
☐ 10 mg/kg x 1, followed by 20 mg/kg every 3 weeks x 7 doses
☐ Other ___________________________

Frequency
N/A
☐ Other ___________________________

Medication route ☐ IV
☐ 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 | Thyroid panel within 6 months of referral prior to initiation of therapy | Hearing test completed prior to treatment

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 _______________________

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