



134 Prince Avenue, Suite B
 Bellingham, WA 98226
 Phone (360) 933-4892
 Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Weight: _____

IV Access: _____

Allergies: _____

Octreotide (Sandostatin) Order Form

◆ **Orders are initiated unless crossed out by provider.**

Check box to initiate orders.

Please complete this form and fax to (360)933-1197. Call our office and our clinical pharmacists will be happy to make therapy recommendations.

Diagnoses:

- | | |
|--|--------------|
| <input type="checkbox"/> Acromegaly | ICD-9: 253.0 |
| <input type="checkbox"/> Carcinoid Syndrome | ICD-9: 259.2 |
| <input type="checkbox"/> Vasoactive intestinal peptide-secreting tumor | ICD-9: 239.0 |
| <input type="checkbox"/> _____ | ICD-9: _____ |
| <input type="checkbox"/> _____ | ICD-9: _____ |

Medication Orders:

- Octreotide _____ mcg _____ times daily for _____ days weeks months
 Route of administration: SubQ IV push over 3 minutes IV infusion over 15-30 minutes
- Santostatin LAR Depot _____ mg IM intragluteally every 4 weeks
- Other: _____
- ◆ Alteplase 2mg IV to de clot central IV access per Infusion Solutions protocol as needed for occlusion.
- ◆ Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- ◆ Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

- If no central IV access, RN to insert peripheral IV and rotate site every 72 to 120 hours or as needed.
- Other: _____

Labs:

- | | | |
|--------------------------------|---------------------------------|--------------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |

Prescriber Signature

Date

Please Print Name