



Infusion Center
Kennebunk • Portsmouth • Scarborough • Topsham
Phone: 207-303-3225 Fax:207-692-2473

Lanreotide (Somatuline) Order Form

Patient Name: _____	DOB: _____	
Diagnosis: _____	Diagnosis Code: _____	
Height: _____(cm)	Actual Weight: _____(kg)	Allergies: _____

Somatuline: 90mg 120mg Other _____
Frequency: _____.

* In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.

Provider Name: _____
Provider Signature: _____ Date: _____
Phone: _____ Fax: _____ Pager: _____