Mississippi PEDIATRIC ENDOCRINE CARE

Precocious Puberty Injection External Clinic Form

Patient Name: _____

DOB: _____

Pt accompanied by: _____

Medication: Please Select

- Lupron DEPOT-PED
- 11.25mg IM Q3 months
- 30mg IM Q3 months
- 45mg IM Q6 months

- Triptodur 22.5mg IM Q6 months

NDC#: _____

Exp Date: _____

Lot#: _____

Location Given: Right Quad or Left Quad

Given by:

Nurse: _____

Clinic: _____

*Please fax this form back to our office at 662-432-0965 or email it to mspedendonurse@mspedendocare.com. For any questions or concerns call the clinic at 662-432-0961 EXT. 3.