



Patient Information (Required for Scheduling)

Patient Name: _____ DOB: _____ Sex: M F SS#: XXX-XX-_____
First & Last Name

Patient's Address: _____
Street City State Zip Code

Home Phone #: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Insurance Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Insurance Phone #: _____
Plan & Product

Order Information – Cortrosyn Stimulation Test

Diagnosis: _____

ICD CM Codes: _____

Test/Service: _____ Cortrosyn Stimulation Test _____

CPT Codes: _____

Physician Orders:

1. Draw blood specimen for baseline cortisol level
2. Administer Cortrosyn 250 mcg IM
3. Draw blood specimen for cortisol level at 30 minutes and 60 minutes after administering Cortrosyn.
4. Observe patient for allergic reaction throughout the course of the test.
5. Patient may be discharged once test is complete and no allergic reaction noted.

Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License #: _____

Physician Address: _____ Phone #: _____ Fax #: _____

I hereby certify that the services indicated in the above order form are medically necessary.

Physician Signature: _____ Date: _____ Time: _____