NORTHEAST REGIONAL
Infusion Services
AT
Richardson
MEDICAL CENTER
PHONE: (318) 728-8237 FAX: (877) 249-1191

☐ **STAT REFERRAL**

ACTH STIMULATION TEST ORDER FORM

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI____ DOB:____________

HT: _________ in WT: ________ ☐ lbs ☐ kg Sex: ☐ Male ☐ Female Allergies: ☐ NKDA, ______________________

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Physician Name______________________ Contact Name ______________________ Contact Phone # ______________________

NPI #:______________________ Tax ID#:______________________ Fax #: ______________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

______________________________ ______________________________

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**______________________

PRESCRIPTION ORDERS

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL POLICY PRN

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
☐	COSYNTROPIN 250 MCG/2 mL (NS)	2 mL	IV Push over 2 minutes	ONCE	1

LABS

SELECT	LAB REQUESTED	FREQUENCY
X	ACTH LEVEL	PRIOR
X	CORTISOL LEVEL	PRIOR AND REPEAT 30 + 60 MINUTES POST INFUSION
☐	Other:	
☐	Other:	
☐	Other:	
☐	Other:	

NOTES/INSTRUCTIONS/OTHER

1) **Vital signs will be measured prior to beginning test AND at completion of test, and with any clinical changes that occur during the test. Notify physician if SBP > 180, DBP > 110, or pulse > 120**

2) **Flush line with 10 mL 0.9% NS then DC IV access.**

Physician's Signature ______________________**Time**______________ **Date**______________
**Signature Must Be Clear and Legible*

Cosignature (If Required)______________________**Time**______________ **Date**______________
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.