Cascade ID & Infusion

Specialty Order Form

Patient:_____	Ordering Provider:_____
DOB:_____ ☐M ☐F Weight: _____ lbs.	NPI:_____
Height:_____ICD-10 Code(s):_____	Practice:_____
Diagnosis: _____	Phone:_____
Allergies: _____	Fax:_____
Primary Care Provider:_____	Contact Name:_____

Has the patient been treated for this condition previously? ☐ No ☐ Yes, medication(s): _____

_____

Is the patient currently on therapy? ☐ No ☐ Yes, medication(s): _____

(ACTH) CORTISOL STIMULATION TEST

☐ **COSYNTROPIN**

- Baseline level lab draw
- Administer Cosyntropin 0.25 mg IV
- 30 minutes post administration lab draw
- 60 minutes post administration lab draw

Quick Checklist for referring Cortrosyn patients.

☐ Include demographic sheet and copy of insurance card(s).

☐ Completed Cascade ID & Infusion Specialty Order Form

☐ Signed RX

☐ Recent Progress Note

Physician's Signature:_____ **Date:**_____