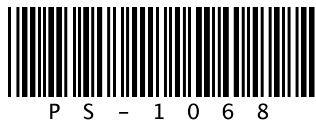
EMORY HEALTHCARE



DTC Cortrosyn Stimulation Test Order
FAX orders to: 404.501.5703
Phone: 404.501.5580

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:** __________________