

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

ICD-10 Diagnosis: \_\_\_\_\_

**Rx: Cortisol Stimulation Test**

Please order:

\_\_\_\_\_ Baseline Cortisol

\_\_\_\_\_ Baseline Adrenocorticotrophic Hormone (ACTH)

\_\_\_\_\_ Cosyntropin (Cortrosyn) 0.25 mg Injection once

Route:  IM = 0.25 mg in 1 mL 0.9% NaCl     IV Push = 0.25 mg in 5 mL 0.9% NaCl over 2 minutes

30 minute Cortisol

60 minute Cortisol

90 minute Cortisol

Other orders/comments: \_\_\_\_\_

**Patient base line should be drawn between 6-8 AM. Patient may eat a low fat diet prior to ordering waiting time.**

Prescriber printed name: \_\_\_\_\_

Prescriber full address: \_\_\_\_\_

Office phone number: \_\_\_\_\_ Office fax number: \_\_\_\_\_

\_\_\_\_\_  
Prescriber signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

*Questions? Call (419) 591-3858. Please fax completed form to (419) 592-4004.*



**CORTISOL STIMULATION  
TEST ORDER FORM**

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*Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc.*

**TRIAL**

***This document is currently being trialed.***