



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
 Primary Language: _____ Allergies: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

- E27.1 Primary Adrenal Insufficiency
- E27.3 Drug-induced Adrenal Insufficiency
- E27.40 Unspecified Adrenocortical Insufficiency
- Other: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, lab results & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

PRESCRIPTION

Pre-Medications

- Acetaminophen: 650 mg PO
- Cetirizine 10 mg PO
- Dexamethasone: _____ mg IV
- Diphenhydramine: 25 mg PO
- Diphenhydramine: 25 mg IV
- Other: _____
- Acetaminophen: _____ mg PO
- Famotidine: _____ mg IV
- Loratadine 10 mg PO
- Methylprednisolone: _____ mg IV
- Ondansetron 4 mg IV

Lab Orders

- CBC w/diff: every _____ weeks month
- CMP: every _____ weeks month
- ACTH stimulation panel (baseline, 30 min, 60 min)
- Other: _____ weeks month

Cosyntropin

Dose/Frequency (SELECT ONE)

- IV: inject 0.25 mg via IVP x 1

Labs to be obtained at baseline, 30 min post administration, and 60 min post administration

** Please inform the patient to not take any stimulant medications or drink caffeine (soda, coffee, energy drinks, etc) prior to appt. IF patient does, appt will be rescheduled

Is the patient on any other disease modifying therapy? Yes No

If yes, please note therapy and last dose: _____

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

PRESCRIBING INFORMATION

Prescriber Name: _____ Signature: _____
 Date: _____ NPI # _____ Specialty: _____
 Office phone #: _____ Office Fax #: _____