Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: ____________________________ Patient D.O.B.________________________

Current Height: ____________________________ Current Weight________________________

Patient Phone # (______) _______-________________ Gender________________________

Patient Address ____

City__________________ State _______________ Zip Code__________________________

Related Diagnosis Code (ICD-10 code): ____

Referring Provider (Please Print) ____

Office Phone # (______) _______-________________ Office Contact: __________________

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

ACTH Stimulation Treatment Plan

Patient Name: ______________________________________ **Patient DOB** _______________________________

General

Diagnosis-_______________________________ ICD-10 Code _______________

Pt. Weight _____________ Pt Height _____________ Known Allergies _____________

Requested Test Date ____/____/_______

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)
every 30 min, Resp, BP, HR, Temperature on admission to the unit and prior discharge

☑ Vital Signs (Month 1 to 12)
as needed if patient experiences adverse reaction until one hour after symptom resolution

Medications
Cosyntropin

☐ *0.25 mg, IV Push, Once*
Comments: To be given immediately after baseline cortisol level

☐ *0.25 mg, Intramuscular,, Once*
Comments: To be given immediately after baseline cortisol level

Laboratory

☐ ACTH Non-Stimulation-(211)
Blood, Timed Study, T;N, Once

☑ Cortisol Baseline
Blood, Timed Study, T;N, Once
Comments: Must coordinate med administration time with Lab draws

☑ **+30 Minutes** Cortisol 30 Minute
Blood, Timed Study, T;N, Once
Comments: Must coordinate med administration time with Lab draws

☑ **+60 Minutes** Cortisol 1 Hour
Blood, Timed Study, T;N, Once
Comments: Must coordinate med administration time with Lab draws

☑ **Communication Order**: Patient must stay in infusion area for 60 min post infusion. If vital signs normal may be discharged to home. Potential side effects include but are not limited to: decreased heart rate, increased heart rate, edema, elevated blood pressure, injection site pain, rash or dizziness. If abnormal, call physician.

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature ____________________________ Provider Name (please print)____________________________

Date _______________________

IV Iron Treatment Plan

☑ **Notify provider** if patient received steroids (i.e. prednisone, dexamethasone, hydrocortisone or spironolactone) within 12 hours of the order for cosyntropin stimulation testing

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature ___________________________ Provider Name (please print)___________________________

Date_____/_____/__________ Patient Name ______________________________ Patient DOB________________