



Cosyntropin Stimulation Referral Form (CRF)

BIOMED Pharmaceuticals

Phone: (817) 923-4495

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Corporate Office
1512 8th Ave. Suite 100
Fort Worth, TX 76104

Desoto
2727 Bolton Boone Dr. Ste 110
Desoto, TX 75115

Houston
1919 N. Loop West, Ste 180
Houston, TX 77008

Tyler
837 S. Fleishel
Tyler, TX 75701

San Antonio
211 North San Saba, Suite 205
San Antonio, TX 78207

Name: _____ Date of Birth: _____ Male _____ Female _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Insurance: _____

Secondary Insurance: _____

Phone #: _____

Phone#: _____

Subscriber: _____ DOB: _____

Subscriber: _____ DOB: _____

ID#: _____ Policy/Group#: _____

ID#: _____ Policy/Group#: _____

Prescription Drug Card _____ Number _____

Statement of Medical Necessity

Weight _____ (lbs) _____ (kg) Diabetic? _____ Yes _____ No

Diagnosis:

- _____ Isolated Growth Hormone Deficiency (253.3)
- _____ Panhypopituitarism (253.2)
- _____ Pituitary Neoplasm (273.0)
- _____ Other disorders of pituitary (253.3)
- _____ Iatrogenic Hypopituitarism (253.7)
- _____ Hypophysectomy induced
- _____ Postablative
- _____ Radiotherapy induced
- _____ Other (specify ICD-9) _____

Height _____

Allergies: _____

Medications: _____ NO _____ YES (please explain) _____

Send Lab Values:

_____ IGF _____ Date: _____ Time Drawn: _____

_____ Other _____ Date: _____ Time Drawn: _____

BASELINE LAB TEST

_____ Blood Sugar _____ GH Cortisol _____

_____ GHBP _____ Other (List Other) _____

_____ Electrolytes _____ IGFBP3 _____

_____ IGF-1 _____ Insulin _____

Stim Test Orders:

NO REFILLS

_____ Cosyntropin Releasing Hormone (CRH) _____ 1.0 ug/kg IVP or _____ 0.25 IVP

_____ 0.9% Sodium Chloride NS as needed to draw labs and start IV _____ Anaphylaxis meds per protocol

Physician Certification: I certify the above therapy is medically necessary, and the information is accurate to the best of my knowledge.

Signature: _____ Date _____

Print Name: _____ DEA# _____ NPI# _____

Address: _____ City: _____ St _____ Zip _____

Phone: _____ Fax: _____ **Thank you for your referral.**



Please send front and back copy of all insurance cards with referral.