ADULT AMBULATORY INFUSION ORDER

Cosyntropin (CORTROSYN) Stimulation Test

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Patient should not receive corticosteroids or spironolactone within 24 hours prior to the cosyntropin test.
3. The Low Dose Protocol is not recommended in critically-ill patients.

LABS:

☐ ACTH Stimulation Test, Serum, Routine, ONCE, every ___ (visit)(days)(weeks)(months) – *Circle One*
☐ Cortisol, Serum Routine, ONCE, ONCE, every ____ (visit)(days)(weeks)(months) – *Circle One*

- Draw baseline immediately before administration of Cosyntropin IVP
- Draw 20 minutes after administration of Cosyntropin IVP (if cosyntropin 1 mcg test is ordered)
- Draw 30 minutes after administration of Cosyntropin IVP
- Draw 60 minutes after administration of Cosyntropin IVP

NURSING ORDERS:

1. Draw baseline ACTH and cortisol labs.
2. Administer Cosyntropin IVP over 2 minutes and flush with 5-6 mL normal saline flush.
3. Draw 30+ and 60+ Cortisol labs.
4. Only use a 22 gauge or larger needle.
5. Release labs as drawn so times are accurate. Do not release all labs at one time
6. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

Cosyntropin (select one):

○ cosyntropin (CORTROSYN) injection 1 mcg, intravenous, ONCE over 2 minutes
Low Dose Protocol. Diluted in sodium chloride 0.9%. Infuse over 2 minutes.
○ cosyntropin (CORTROSYN) injection 0.25 mg, intravenous, ONCE over 2 minutes
Standard Dose Protocol. Diluted in sodium chloride 0.9%. Infuse over 2 minutes.

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610