Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

Cosyntropin (CORTROSYN) Stimulation Test

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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.

OHSU Health **Oregon Health & Science University Hospital and Clinics Provider's Orders** ADULT AMBULATORY INFUSION ORDER **Cosyntropin (CORTROSYN) Stimulation Test** Page 2 of 2	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