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 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. Release labs as drawn so times are accurate. Do not release all labs at one time
5. 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 NS. Infuse over 2 minutes.
- [ ] Cosyntropin (CORTROSYN) Injection 0.25 mg, intravenous, ONCE over 2 minutes
  - Standard Dose Protocol. Diluted in NS. Infuse over 2 minutes.
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: ____________

OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

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

☐ Beaverton
  OHSU Knight Cancer Institute
  15700 SW Greystone Court
  Beaverton, OR 97006
  Phone number: 971-262-9000
  Fax number: 503-346-8058

☐ NW Portland
  Legacy Good Samaritan campus
  Medical Office Building 3, Suite 150
  1130 NW 22nd Ave.
  Portland, OR 97210
  Phone number: 971-262-9600
  Fax number: 503-346-8058

☐ Gresham
  Legacy Mount Hood campus
  Medical Office Building 3, Suite 140
  24988 SE Stark
  Gresham, OR 97030
  Phone number: 971-262-9500
  Fax number: 503-346-8058

☐ Tualatin
  Legacy Meridian Park campus
  Medical Office Building 2, Suite 140
  19260 SW 65th Ave.
  Tualatin, OR 97062
  Phone number: 971-262-9700
  Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders