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.
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:__________

Central Intake:
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