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

PO7071

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.

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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**: _____

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