LIFEBRIDGE HEALTH.
CARE BRAVELY

ACTH STIMULATION/ COSYNTROPIN (Cortrosyn®) ORDER FORM

Patient Label

Date: _____

Patient Name: _____ DOB: _____

Diagnosis: _____ Diagnosis Code: _____ Height: _____

Allergies: _____ Weight: _____

Pre-appointment Documentation:
Please fax most recent office visit note documenting the patient's diagnosis as well as a copy of the patient's demographic information along with this order form.

Treatment:

☒ **Cosyntropin** 0.25mg diluted with NS to 5mL, IV over 2 minutes

Lab Orders:

☒ Cortisol level, baseline

☒ Cortisol level, 30 minutes after cosyntropin administration

☒ Cortisol level, 60 minutes after cosyntropin administration

☒ **Hypersensitivity/Anaphylaxis Medications and Extravasation Management (PRN):** Follow Adult Hypersensitivity Protocol as needed per Nursing Protocol for the treatment of allergic/hypersensitivity reaction. Follow established hospital protocol for extravasation.

Physician's Name (Print): _____ Signature: _____ Date: _____

Contact Number: _____ Fax Number: _____

SINAI HOSPITAL
FAX TO: 410-601-4452
410-601-9311
PHONE: 410-601-4779

NORTHWEST HOSPITAL
FAX TO: 410-521-7385
410-521-8889
PHONE: 410-521-8393

Wm. E. KAHLERT CANCER CENTER (CARROLL HOSPITAL)
FAX TO: 410-871-6521
PHONE: 410-871-6400