LIFEBRIDGE HEALTH
CARE BRAVELY

ACTH STIMULATION/ COSYNTROPIN (Cortrosyn®) ORDER FORM

Patient Name: _____ DOB: _____

Allergies: _____ Height (cm): _____ Weight (kg): _____

Diagnosis: _____ Diagnosis Code: _____

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Financial authorizations require clinical documentation of medical necessity. To ensure compliance, the criteria below must be indicated as completed by office representative. Incomplete documentation will be returned to the referring office for completion, resulting in delays to the patient receiving treatment.

- ☐ Ordering provider is credentialed at Sinai Hospital (Alvin and Lois Lapidus Cancer Center) or Carroll Hospital (William E. Kahlert Regional Cancer Center) to admit and write orders.
- ☐ Demographics / insurance information attached, or available in Cerner.
- ☐ Provider note dated within 30 days indicating medical need attached, or date if available in Cerner: _____

Treatment:

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

Lab Orders:

- ☒ Cortisol level, baseline
- ☒ Cortisol level, 30 minutes after cosyntropin administration
- ☒ Cortisol level, 60 minutes after cosyntropin administration
- ☐ 17-Hydroxyprogesterone level, baseline
- ☐ 17-Hydroxyprogesterone level, 60 minutes after cosyntropin administration
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Protocol Orders:

- ☒ Hypersensitivity/Anaphylaxis**:** Follow Adult Hypersensitivity Protocol PRN per Nursing Protocol for treatment of hypersensitivity reaction.
- ☒ Extravasation Management: Follow established protocol for extravasation as needed.
- ☒ Port Care and Flush per Nursing Protocol: single-lumen flush protocol or double-lumen flush protocol as appropriate.

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

Contact Number: _____ Fax Number: _____

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