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: ______________________

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