Outpatient Cortisol Stimulation Test

Klickitat Valley Health
Phone: 509-772-2695 Fax: 509-773-3354

General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone #_____

Order Start Date _____ Order Expiration Date _____

Allergies: _____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.

DIAGNOSIS CODE:

☐ E27.4 Unspecified adrenocortical insufficiency

☐ Other: _____

Nursing Orders

IV ACCESS: ☒ Place peripheral IV

☒ Vital Signs: baseline and every 30 minutes until discharge.

☒ Do not administer Cortrosyn (cosyntropin) if the patient has received corticosteroids in the 24 hours prior to the test *unless* approved by the ordering provider.

Procedure Orders

Baseline Bloodwork

☒ Draw baseline serum cortisol and ACTH labs

☐ Additional baseline labs:

_____

_____

Medication

☒ Administer 0.25mg cosyntropin IV

Timed Bloodwork

☒ Draw serum cortisol and ACTH labs 30 and 60 minutes post cosyntropin administration

☒ May draw all labs for this procedure from IV site per KVH Lippincott procedure "IV Catheter Blood Sampling"

IF ANAPHYLACTIC REACTION OCCURS

☒ Notify provider and/or Hospitalist on duty if afterhours, administer oxygen prn, administer Benadryl 50 mg IV or IM once STAT, administer Epinephrine (1:1000) 0.5mg IM once STAT, possible admission to emergency department for further evaluation/treatment.

Patient Name:
DOB:

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Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in _____ *(specify state)*

My physician license number is # _____ 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 _____

Printed name: _____ Phone: _____ Fax: _____

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: _____ Date _____

Printed name: _____

Patient Name:
DOB: