LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
For Referrals: (541) 271-2163 – Press #3 (all other services) then press # 2 (Referrals)
For Outpatient Nursing: (541) 271-2171 ext. 5205
FAX: (541) 271-5433

COSYNTROPIN (*CORTROSYN)* STIMULATION TEST

Patient Name _____ **DOB** _____

Patient Phone # _____ **Patient Weight (Kg)** _____ **Patient Height (cm):** _____

Patient Allergies _____

Provider _____ **NPI#** _____

ICD-10 Code (REQUIRED) _____ **J Code** _____

Primary Diagnosis _____

Secondary Diagnosis _____

Duration (or # of treatments): _____ **Anticipated Infusion Date** _____

INSTRUCTIONS TO PROVIDER:

- ***Please ensure insurance authorization has been initiated.***
- *Lab orders should NOT be included on this form – place orders via usual method.* ***Lab monitoring is the responsibility of the ordering Provider.***
- *This plan will expire* ***after 365 days****, at which time new orders will need to be placed.*

MEDICATIONS:

☐ CONVENTIONAL DOSE: **cosyntropin** *(CORTROSYN)* 0.25 mg in **0.9 % sodium chloride** IV **x** 1 over 2 minutes

Other:_____

ORDERING GUIDELINES:

☒ Send **FACE SHEET and H&P** or most recent chart note
☒ Patient **should not receive** corticosteroids or spironolactone within 24 hours prior to cosyntropin test

LAB - NURSE DRAW:

☒ ACTH Stimulation Test, serum **x** 1
☒ Cortisol series **x** 3, serum: baseline immediately before administration of cosyntropin, then 30 minutes after administration of cosyntropin, then 60 minutes after administration of cosyntropin

NURSING ORDERS:

☒ Draw baseline ACTH and Cortisol labs. Administer **cosyntropin** IVP over 2 minutes and flush with 5 to 6 mL **0.9% sodium chloride**. Draw 30 minutes and 60 minutes Cortisol labs.

HYDRATION / MAINTENANCE TKO:

☒ **0.9% sodium chloride** infusion, 25 mL/hour IV **x** 1 PRN per policy - flush/hydration/main bag/TKO
☐ **dextrose 5%** infusion, 25 mL/hour IV **x** 1 PRN per policy - flush/hydration/main bag/TKO

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Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

Patient Label

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Patient Name _____ **DOB** _____

LINE CARE MAINTENANCE:

- ☒ Follow facility policies and procedures for all vascular access maintenance with appropriate flush solutions, de-clotting (**alteplase**), and/or dressing changes.
- ☒ **alteplase** *(CATHFLO ACTIVASE)* injection 2 mg/2 mL, intra-catheter **x** 1 PRN de-clotting per facility policy **x** 2 doses
- ☒ **heparin,porcine (Preservative Free)** 100 units/mL IV syringe, 500 units, intra-catheter **x** 1 PRN line care
- ☒ **0.9% sodium chloride** flush, 10 to 30 mL IV - See facility policy and/or medication administration instructions; flush as needed.
- ☒ If applicable, may remove PICC line at the completion of course of therapy

EMERGENCY MEDICATIONS FOR HYPERSENSITIVITY / INFUSION REACTION:

****** *Itching, hives, fever* ******

- ☒ **STOP MEDICATION INFUSION if allergic reaction occurs**
- ☒ Establish IV access and infuse **0.9% sodium chloride** 500 mL at 25 mL/hour PRN Hypersensitivity / Allergic reaction
- ☒ VS Q15 minutes **x** 4 and PRN
- ☒ **acetaminophen** *(TYLENOL)* 650 mg PO Q4HRS PRN Hypersensitivity / Allergic Reaction.
- ☒ **diphenhydramine** *(BENADRYL)* 25 mg IVP PRN Hypersensitivity / Allergic Reaction **x** 1 dose. May repeat **x** 1 ***{Maximum dose = 50 mg}***
- ☒ **NOTIFY** Provider of Hypersensitivity / Allergic Reaction
- ☒ **hydrocortisone** 100 mg IVP PRN Hypersensitivity / Allergic Reactions **x** 1 dose if reaction continues and is not relieved by maximum dose of **diphenhydramine**

ANAPHYLAXIS REACTION

******* Wheezing, Dyspnea, Hypotension, Angioedema, Chest pain, Tongue swelling* ******

- ☒ Transfer to Emergency Department (ED) as needed, and **NOTIFY** Provider
- ☒ **epinephrine** 0.3 mg IM PRN anaphylaxis **x** 1 dose

Date _____ Time _____ Provider Signature _____

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