

BEAUMONT INFUSION CENTERS

CORTROSYN STIMULATION TEST

Location / Royal Oak : 248- 551-3168 Troy : 248-964-2409 Lenox : 947-523-4061 Wayne : 734-467-2505
 Fax Number Grosse Pointe : 586-498-4497 Farmington Hills : 248-471-8217 Dearborn : 313-593-5802 Livonia : 734-542-3356

Patient Name:		Date of Birth:	Medical Record #:
Physician Name:	Address:		Office #:
Diagnosis:		Diagnosis Code (ICD-10):	

PATIENT INFORMATION
<p>Please attach these <u>required</u> documents to Prescription (if not in EPIC):</p> <ul style="list-style-type: none"> <input checked="" type="radio"/> Copy of Insurance Card <input checked="" type="radio"/> Labs <input checked="" type="radio"/> Supporting clinical documentation <input checked="" type="radio"/> Patient Demographics <p><input type="checkbox"/> NKDA</p> <p><input type="checkbox"/> Drug Allergies: _____</p>
<p>Height: _____ ft _____ in Weight: _____ kg / lbs Date: _____</p>

MEDICATION	PROCEDURE
<p>CORTROSYN STIMULATION TEST</p>	<p>Procedure:</p> <ul style="list-style-type: none"> • Start IV lock. • Draw baseline serum blood sample using a 5 ml gold top SST tube. • Administer Cosyntropin 0.25 mg <input type="checkbox"/> IV Push over 2 minutes, OR <input type="checkbox"/> IM • Draw serum blood samples at 30 and 60 minutes after cosyntropin administration. • Label specimens accurately according to interval drawn. • Send to laboratory for processing. <p>Reaction Orders:</p> <ul style="list-style-type: none"> • Notify referring physician • Adult Standard Anaphylaxis Protocol <p>Flush Orders:</p> <ul style="list-style-type: none"> • NaCL 0.9% 10 ml flush per protocol.

Physician Signature _____ Beeper # _____ Date _____ Time _____