

ACTH STIMULATION TEST ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ ☐ lbs ☐ kg Sex: ☐ Male ☐ Female Allergies: ☐ NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION)

Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

Does patient have venous access? ☐ YES ☐ NO If yes, what type ☐ MEDIPORT ☐ PIV ☐ PICC LINE ☐ OTHER: _____

PRESCRIPTION ORDERS

- a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL POLICY PRN

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
☐	COSYNTROPIN 250 MCG/2 mL (NS)	2 mL	IV Push over 2 minutes	ONCE	1

LABS

NOTES/INSTRUCTIONS/OTHER

SELECT	LAB REQUESTED	FREQUENCY	
X	ACTH LEVEL	PRIOR	
X	CORTISOL LEVEL	PRIOR AND REPEAT 30 + 60 MINUTES POST INFUSION	
☐	Other:		
☐	Other:		
☐	Other:		

- Vital signs will be measured prior to beginning test AND at completion of test, and with any clinical changes that occur during the test. Notify physician if SBP > 180, DBP > 110, or pulse > 120
- Flush line with 10 mL 0.9% NS then DC IV access.

Physician's Signature _____ Time _____ Date _____
*Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____
*Signature Must Be Clear and Legible