



Change order details by crossing out unwanted information and writing in desired details/instructions. Place a line through the **x** to remove the pre-checked option.

## ACTH STIMULATION TESTING Columbia Network Infusion Centers

Select Location:    Southwest/Vancouver    St John/Longview   Start Date: \_\_\_\_\_

Diagnosis/Indication: \_\_\_\_\_

ICD-10 Code(s): \_\_\_\_\_ Authorization Number: \_\_\_\_\_

Patient Vitals: Height \_\_\_\_\_ Weight \_\_\_\_\_

### Provider Communication Orders

To reduce delays in treatment and phone calls to your office, you may participate in the PeaceHealth formulary process by selecting this option. A clinic pharmacist will adjust orders according to PeaceHealth site approved policies and procedures.

- I agree to utilize the PeaceHealth policies & procedures that have been reviewed by the Pharmacy & Therapeutics Committee and authorized by the Medical Executive Committee of PeaceHealth. This agreement will be issued for the duration of active orders contained within this treatment plan.**

Labs	Interval
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- ACTH Stimulation Standard Once  
*Includes baseline, 30 minute, and 60 minute draws*

Supportive Care	Interval
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- cosyntropin (CORTROSYN) injection Route: IV  
*0.25 mg, IV, Once, Validate the baseline cortisol lab is collected first before Cortrosyn / ACTH is administered*

Nursing Orders	Interval
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- Nursing Communication Once  
*This is intended to test the patient's adrenal function. The timing of the medication administration and lab draws are crucial to the interpretation of the study. Please note if patient has received prednisone, methylprednisolone, or hydrocortisone in the last 24 hours and confirm with MD if they still wish to complete ACTH Stim test.*
- Nursing Communication Once  
*Draw lab at baseline, 30 minutes, and 60 minutes - Cortisol Lab*

Vascular Access (single select)	Interval
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- IV Every Visit
  - Insert peripheral IV
  - sodium chloride (NS) flush 10 mL  
*10 mL As Needed for Line Care*
- Central line (non-PICC) Every Visit
  - Access vascular device and confirm patency
  - Initiate Central line (non-PICC) maintenance protocol
  - sodium chloride (NS) flush 10 mL  
*10 mL As Needed for Line Care prior to medication administration PRN*

Provider Signature	Date	Time
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Provider's Printed Name: \_\_\_\_\_

Place Patient Label Here

- sodium chloride (NS) flush 10 mL  
*10 mL As Needed for Line Care post medication administration PRN*
- sodium chloride (NS) flush 20 mL  
*20 mL As Needed for Line Care post lab draw PRN*
- sodium chloride (NS) flush 10 mL  
*10 mL for Line Care at discharge and de-access every visit*
- heparin 100 units/mL 5 mL  
*5 mL for de-access PRN*
- alteplase (CATHFLO) injection 2 mg  
*Other, Starting when released, For 2 dose, PRN, For clearing central line catheter. Add 2.2 mL sterile water for injection to vial; let the vial stand undisturbed to allow large bubbles to dissipate. Mix gently swirling until completely dissolved (complete dissolution should occur within 3 minutes); do not shake. Final concentration: 1 mg/mL. Retain in catheter for 30 minutes to 2 hours, instill a 2nd dose if occluded*

○ PICC line

Every Visit

- Access vascular device and confirm patency
- Initiate PICC maintenance protocol
- Nursing Communication  
*Change PICC line dressing weekly and PRN*
- sodium chloride (NS) flush 10 mL  
*10 mL As Needed for Line Care prior to medication administration PRN*
- sodium chloride (NS) flush 10 mL  
*10 mL As Needed for Line Care post medication administration PRN*
- sodium chloride (NS) flush 20 mL  
*20 mL As Needed for Line Care post lab draw PRN*
- alteplase (CATHFLO) injection 2 mg  
*Other, Starting when released, For 2 dose, PRN, For clearing central line catheter. Add 2.2 mL sterile water for injection to vial; let the vial stand undisturbed to allow large bubbles to dissipate. Mix gently swirling until completely dissolved (complete dissolution should occur within 3 minutes); do not shake. Final concentration: 1 mg/mL. Retain in catheter for 30 minutes to 2 hours, instill a 2nd dose if occluded*

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Provider Signature

Date

Time

Provider's Printed Name:

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Place Patient Label Here

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**ACTH STIMULATION TESTING**