SYNACTHEN TEST

Surname	Given Names	Title	DOB / /
Sex	**Address**	**Phone no.**	**NHI**
Collection Centre Code:	**Full Staff Name:**	**Date:**	**Time:**

About your test

- Your medical practitioner has requested a test that involves the injection of Synacthen into the muscle. This should stimulate your adrenal glands to make more cortisol.
- Reactions to Synacthen rarely occur. To help avoid a reaction information about your past and current medical history is required.

Questionnaire

1. Have you ever been given synacthen as treatment, or had a Synacthen test? **Yes** ☐ **No** ☐
2. If YES, did you have any reaction to the Synacthen injection? **Yes** ☐ **No** ☐

If yes, please provided details:_____

3. Do you have Asthma? **Yes** ☐ **No** ☐
4. Do you have any allergies? **Yes** ☐ **No** ☐

If yes, please provided details:_____

If the patient has had a previous reaction to Synacthen injection or has asthma or any allergies contact the Chemical Pathologist before proceeding

5. Date & Time **Cortisone last taken**: **Date:** _____ **Time:** _____

The patient is required to remain in the Labtests Collection Centre for the duration of the test (approx. 1 hour)

I, _____ have read and understood the above and consent to having the Synacthen test
Print Name (Patient/Parent/Guardian)

Signature: _____ Date: _____

The following information is to be completed by the person administering the Synacthen	
Synacthen Batch Number:	*Verified by:*
Synacthen Expiry Date:	*Verified by:*
Name of person administering Synacthen	
Signature of person administering Synacthen	
***Time** pre Synacthen blood sample taken*	
***Time** Synacthen injection given*	
***Time** post Synacthen blood sample taken*	