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**Synacthen Patient Consent Form and Worksheet**

Full Name………………………………………………………………………………………..

Date of Birth…………………

* Are you taking any prescription medication that may interfere with this test e.g. Prednisone, Cortisone, Hydrocortisone, Dexamethasone, and Betamethasone?
* Last Dose ………………………… (The Patient must not have taken steroids for at least 8 hrs prior to the test).
* Are you pregnant / breast feeding………………..
* Do you suffer from an allergic disorder e.g. Asthma?
  + N.B Ensure patient has current medication with them including asthma inhaler.
* Have you had a previous reaction to any injection or vaccination? You may experience minor side effects following the Synacthen injection:
* Local redness and tenderness at the injection site
* Hot flushing
* Skin itchiness and rash
* Drowsiness

The phlebotomist will observe you for any signs of discomfort throughout this test procedure.

I understand the verbal information given and I consent to this procedure:

Signed…………………………………………… Date…………………

Injection Name………………………………………… Dose………………………………………..

Batch No………………………………………………. Expiry Date…………………………………

Injection Site………………………………………….. Needle Gauge……………………………..

Administered By ……………………………… Date………………………… Time……………..….

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