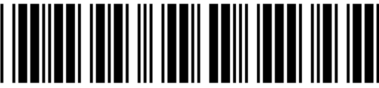
Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071 

ADULT AMBULATORY INFUSION ORDER
Sodium Thiosulfate Infusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: ____________kg **Height:** ____________cm

Allergies: ____

Diagnosis Code: ____

Treatment Start Date: _____________ **Patient to follow up with provider on date:** ___________________

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note.**
2. If patient is a dialysis patient, sodium thiosulfate is to be administered same day after hemodialysis sessions. If applicable, indicate dialysis schedule:
   ____
3. Baseline ECG is required prior to starting treatment. Future ECG monitoring is required for males with baseline QTc greater than 450 ms, females with baseline QTc greater than 470 ms, or if patient has increased risk factors that require further monitoring. Provider to determine frequency of ECG monitoring.
   - ☐ 12 lead ECG will be provided every _____ (visit)(days)(weeks)(months) – Circle One
   - ☐ Baseline QTc _____, proceed with treatment based on baseline QTc and without regular QTc monitoring.

LABS:

☑ Complete Metabolic Panel, Routine, ONCE, every visit.

NURSING ORDERS:

1. TREATMENT PARAMETER #1 – Hold treatment and notify provider if anion gap greater than 12 mEq/L or corrected Ca less than 8.4 mg/dL.
2. TREATMENT PARAMETER #2 – If current ECG has been obtained, hold treatment and notify provider for QTc greater than 500 msec.
3. For initial or prior infusion reactions (including nausea): infuse sodium thiosulfate over 60 minutes. For subsequent infusions: infuse sodium thiosulfate over 30 minutes.
4. Patient may experience hypotension during infusion, ensure patient is in a reclined or semi-reclined position during the sodium thiosulfate infusion.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

☑ Sodium thiosulfate 25 g IV, ONCE over 60 minutes, via CENTRAL LINE

Interval (must check one):

☐ Repeat every _____ days for _____ doses
☐ Repeat _____ times weekly for _____ doses
☐ Other: ______________________________

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HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ ________________ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _________________ <u>(MUST BE COMPLETED TO BE A VALID PRESCRIPTION)</u>; and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: ______________________________ **Date/Time:** ______________________

Printed Name:______________________________ **Phone:** ________________ **Fax**:_____________

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Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders