attach patient label here

Methodist Le Bonheur Healthcare

Physician Orders ADULT

Order Set: Alteplase for Peripheral Revascularization Orders

[**R**] = will be ordered
T= Today; N = Now (date and time ordered)
Height: _____cm Weight: _____kg

Allergies:		[ ] No known allergies
[ ]Medication allergy(s): _____		
[ ] Latex allergy [ ]Other: _____		
	NOTE: These orders are NOT to be used for patients experiencing a stroke or pulmonary embolism.	
[R]	Alteplase for Peripheral Revascularization Protocol Orders	T;N
Standard Concentration Infusion		
	NOTE: Alteplase standard concentration of 25 mg / 250 mL NS = 0.1mg/mL, see orders below:	
[ ]	alteplase infusion for periph revascularization - std conc	225 mL,IV,STAT,(for 24 hr), See Order Comments, **Comments:** Alteplase standard concentration (25 mg / 250 mL diluent = 0.1 mg/mL) Initial infustion rate: _____ mg/hr (_____ mL/hr) for _____ hours - THEN - Infusion rate: _____ mg/hr (_____ mL/hr) Infusion site = _____
HIGH Concentration Infusion		
	NOTE: Alteplase HIGH concentration of 25 mg / 25 mL NS = 1 mg/mL, see orders below:	
[ ]	alteplase infusion for periph revascularization - HIGH conc	25 mL,IV,STAT,(for 24 hr), See Order Comments, **Comments:** Alteplase HIGH concentration (25 mg / 25 mL diluent = 1 mg/mL) Initial infustion rate: _____ mg/hr (_____ mL/hr) for _____ hours - THEN - Infusion rate: _____ mg/hr (_____ mL/hr) Infusion site = _____
HIGH Concentration Bolus for IV Push		
[ ]	alteplase	_____ mg, Injection, IV Push, once, STAT, **Comments**: IV Bolus for Peripheral Revascularization
Laboratory		
[ ]	CBC	STAT, once, Type: Blood
[ ]	CBC	Time Study, T;N+240, q4h, Type: Blood
[ ]	Partial Thromboplastin Time (APTT)	STAT, once, Type: Blood
[ ]	Partial Thromboplastin Time (APTT)	Time Study, T;N+240, q4h, Type: Blood
[ ]	INR Normalized PT Ratio (INR)	STAT, once, Type: Blood
[ ]	INR Normalized PT Ratio (INR)	Time Study, T;N+240, q4h, Type: Blood
[ ]	Fibrinogen Level	STAT, once, Type: Blood
[ ]	Fibrinogen Level	Time Study, T;N+240, q4h, Type: Blood

_____ _____ _____ _____

Date **Time** **Physician's Signature** **MD Number**