



ORD

| ORDERED |      | ISCHEMIC STROKE POST ACTIVASE (rt-PA) ORDERS  | TIME        |
|---------|------|---|-------------|
| DATE    | TIME |   | ORDER NOTED |
|         |      | <i>Check appropriate boxes.</i>   |             |
|         |      | <b>Allergies:</b> _____ <b>Height</b> _____ <b>Weight</b> _____   |             |
|         |      | <b>1) Patient Status:</b> <input type="checkbox"/> Inpatient  |             |
|         |      | <b>2) Location:</b> <input type="checkbox"/> Critical Care  |             |
|         |      | <b>3) Attending Physician:</b> _____  |             |
|         |      | <b>4) Diagnosis:</b> _____  |             |
|         |      | <b>5) Call MD for any neurological changes:</b> decline in neuro checks, change in pupil reaction or size, headache, or vomiting.   |             |
|         |      | <b>6) If hemorrhage is suspected,</b> Notify MD IMMEDIATELY and implement Hemorrhage Post Activase (rt-PA) Protocol as ordered. (See page 3)                                |             |
|         |      | <b>7) Do not administer</b> Aspirin, clopidogrel, heparin, enoxaparin sodium, warfarin, NSAIDs or any other antithrombotic for 24 hours after infusion of Activase (rt-PA). |             |
|         |      | <b>8) No IM injections,</b> arterial punctures, Foley catheter, NG tube or other invasive procedures for 24 hours after infusion of Activase (rt-PA).                       |             |
|         |      | <b>9) Do not remove IV lines</b> for 24 hours after infusion of Activase (rt-PA).   |             |
|         |      | <b>10) <input type="checkbox"/> Accuchecks q 6 hours</b> <input type="checkbox"/> Follow <b>Diabetes Management Bundle</b>  |             |
|         |      | <b>11) Weigh</b> on admission and daily   |             |
|         |      | <b>12) Maintain normothermia</b> (98.6-99.5 F). Implement cooling measures (cool room, light covering, prn medication) Notify MD if unable to normalize within 2 hours.     |             |
|         |      | <b>13) Vital signs</b> q 15 min. x 2 hours, then q 30 min. x 6 hours, then hourly thereafter  |             |
|         |      | <b>14) Neuro checks</b> q 30 min x 2 hours, then hourly thereafter  |             |
|         |      | <b>15) O2</b> per nasal cannula at _____ L/min or other oxygen via _____ to keep SpO2 > 92%. Continuous Pulse Oximetry. Notify MD if unable to keep SpO2 > 92%.             |             |
|         |      | <b>16) Cardiac monitoring</b>   |             |
|         |      | <b>17) I &amp; O.</b> Bladder scan if no void in 4 hours. <b>Notify MD</b> if volume > 450cc.   |             |
|         |      | <b>18) Activity: Fall precautions and</b>   |             |
|         |      | <input type="checkbox"/> Bedrest and turn every 2 hours x 24 hours  |             |
|         |      | <input type="checkbox"/> HOB elevated 30 degrees if systolic BP > 100 mmHg  |             |
|         |      | <input type="checkbox"/> Maintain head/neck in neutral position   |             |
|         |      | <input type="checkbox"/> Up in chair TID on Day 2. If patient is eating, must be up with meals  |             |
|         |      | Additional activity orders _____  |             |
|         |      | <b>19) Diet:</b> <input type="checkbox"/> Strict NPO until patient <b>Passes Nursing Dysphagia Screen</b>   |             |
|         |      | Passed Nursing Dysphagia Screen? <input type="checkbox"/> <b>Pass</b> <input type="checkbox"/> <b>Fail</b>  |             |
|         |      | <b>Nurse Signature:</b> _____ <b>Date/Time:</b> _____   |             |
|         |      | If patient <b>passes</b> Dysphagia Screen begin: Diet: _____  |             |
|         |      | If patient <b>fails</b> Dysphagia Screen consult Speech Therapy <b>ASAP</b> for dysphagia evaluation and notify MD for further nutrition/hydration.                         |             |
|         |      | <b>Physician Signature:</b> _____ <b>Date/Time:</b> _____   |             |

▼ Addressograph / Patient Label ▼



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|         |      | <b>20) Diagnostic Studies:</b>  |                  |
|         |      | <input type="checkbox"/> CT Brain: <input type="checkbox"/> Without contrast <input type="checkbox"/> With contrast   |                  |
|         |      | <input type="checkbox"/> STAT <input type="checkbox"/> Today <input type="checkbox"/> In AM   |                  |
|         |      | <input type="checkbox"/> MRI/MRA stroke protocol <input type="checkbox"/> STAT <input type="checkbox"/> Routine scheduling  |                  |
|         |      | <input type="checkbox"/> Carotid ultrasound <input type="checkbox"/> Today <input type="checkbox"/> In AM   |                  |
|         |      | <input type="checkbox"/> Chest X-ray <input type="checkbox"/> Today <input type="checkbox"/> In AM  |                  |
|         |      | <input type="checkbox"/> EKG <input type="checkbox"/> Today <input type="checkbox"/> In AM  |                  |
|         |      | <input type="checkbox"/> Standard Echocardiogram <input type="checkbox"/> Today <input type="checkbox"/> In AM  |                  |
|         |      | *Echo to be read by: <input type="checkbox"/> Dr. Bart Williams   |                  |
|         |      | <input type="checkbox"/> Dr. Boland   |                  |
|         |      | <input type="checkbox"/> Other _____  |                  |
|         |      | <b>Consult Cardiology for TEE:</b> <input type="checkbox"/> Dr. Bart Williams   |                  |
|         |      | <input type="checkbox"/> Dr. Boland   |                  |
|         |      | <input type="checkbox"/> Other _____  |                  |
|         |      | <b>21) Labs:</b> CMP <input type="checkbox"/> if not done in the ED <input type="checkbox"/> in am  |                  |
|         |      | CBC <input type="checkbox"/> if not done in the ED <input type="checkbox"/> in am   |                  |
|         |      | PT/PTT <input type="checkbox"/> if not done in the ED <input type="checkbox"/> in am  |                  |
|         |      | Fasting Lipid Profile <input type="checkbox"/> in am  |                  |
|         |      | UA <input type="checkbox"/> if not done in the ED   |                  |
|         |      | <input type="checkbox"/> ESR <input type="checkbox"/> ANA <input type="checkbox"/> RPR <input type="checkbox"/> Hgb A1C   |                  |
|         |      | <input type="checkbox"/> Hypercoagulability Panel with consultation   |                  |
|         |      | <input type="checkbox"/> Homocysteine   |                  |
|         |      | <input type="checkbox"/> Leiden Factor V  |                  |
|         |      | <b>Additional Labs:</b> _____   |                  |
|         |      | <b>22) Blood Pressure Management after Activase (t-PA) administration</b>   |                  |
|         |      | <input type="checkbox"/> If SBP > 180 and < 230 mmHg OR DBP 106 to 120 mmHg administer:<br>Labetalol 10-20 mg IV over 1-2 min; may repeat every 10 min (max dose 300 mg)  |                  |
|         |      | <input type="checkbox"/> If SBP > 230 mmHg OR DBP 121 to 140 mmHg administer:<br>Labetalol 10-20 mg IV over 1-2 min; may repeat every 10 min (max dose 300 mg)<br>If Labetalol not effective begin Nicardipine (50mg/250ml D5W) @ 5mg/hr and titrate to desired effect<br>by increasing 2.5 mg/hr every 5-15 min to max. of 15 mg/hr. |                  |
|         |      | <input type="checkbox"/> If DBP > 140 mmHg administer Nitroprusside 0.5 mcg/kg/min IV infusion. Titrate to a maximum dose<br>of 5 mcg/kg/min. Caution in renal patients.  |                  |
|         |      | <b>23)</b> <input type="checkbox"/> INT <input type="checkbox"/> 1/2 NS at _____ ml/hr <input type="checkbox"/> NS at _____ ml/hr   |                  |
|         |      | <input type="checkbox"/> Add 20mEq KC1 to each liter  |                  |
|         |      | All IV medications are to be mixed in normal saline.  |                  |
|         |      | <b>24) DVT prophylaxis:</b> <input type="checkbox"/> Apply SCDs   |                  |
|         |      | Physician Signature: _____  | Date/Time: _____ |



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