**Physician Orders**

**Neuro Heparin Infusion [30400581]**

- Discontinue all IM medications and all NSAIDS
- Discontinue all other injectable heparin and low molecular weight heparins, except heparin catheter flushes

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Allergies</th>
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**General**

Notify Provider

- Discontinue all other injectable heparin and low molecular weight heparins, except catheter flushes
- Discontinue all IM medications and all NSAIDS

Notify Provider if baseline Results abnormal

Routine, Until discontinued, Starting today, If baseling Hemogram, PTT, and PT/INR results are abnormal

**Nursing Assessment**

Adjust dose for obesity [obesity is defined as actual body weight (ABW) being 20% greater than ideal body weight (IBW)]: use dosing weight \( (DW) = IBW + 0.4(ABW - IBW) \)

- Obtain patient height
  - Routine, Once, Starting today For 1 Occurrences
- Obtain patient weight
  - Routine, Daily, Starting today

**Lab**

**Baseline Labs**

Order these only if not already done

- CBC, no diff (hemogram) - Baseline
  - Once, Starting today
  - Hemogram baseline. Draw lab prior to heparin infusion if no baseline lab values are available.
- Activated partial thromboplastin time - Baseline
  - Once, Starting today
  - Draw lab prior to heparin infusion if no baseline lab values are available.
- Protine-INR - Baseline
  - Once, Starting today
  - Draw lab prior to heparin infusion if no baseline lab values are available.

**Hematology**

- Hemogram every 3 days while on heparin infusion
  - Every 72 hours, Starting today

**Coagulation**

- Stat Anti-Xa level (Hep UFH) every 6 hours after heparin initiated
  - Every 6 hours, Starting today For Until specified
  - Do not draw anti-Xa level sooner than six hours, and do not adjust heparin infusion before six hours unless adverse events occur.
- When two (2) consecutive Anti-Xa levels are in therapeutic range, check Anti-Xa (UFH) level daily at 1300 and with each dosage change.
  - Routine, Until discontinued, Starting today
- No further PTT levels to be drawn (after baseline) while patient is on heparin infusion
  - Routine, Until discontinued, Starting today, All results will be elevated or "critical" per laboratory normal values.

**Provider Initial:**
### Occult Blood

| [X] Hemoccult stools X 3 panel | Routine, Once, Starting today For 3 Occurrences, Starting today for 3 occurrences. |
| [X] POCT occult blood stool   | Routine, Once, Starting today For 1 Occurrences |
| [X] Notify Provider           | Pulse greater than: Respiratory rate less than: Respiratory rate greater than: Temperature greater than (celsius): Urine output less than (mL/hr): Systolic BP greater than: Systolic BP less than: Diastolic BP greater than: Diastolic BP less than: Other: Of first positive occult blood. |

### Medication

**Heparin Infusions**

Recommendation: Heparin Bolus is NOT recommended in acute cerebral infarction

| [X] Pharmacy general consult - Heparin | Routine, Once, Starting today |
| [X] heparin infusion 50 units/mL in 0.45% NaCl | 15 Units/kg/hr, IntraVENous, Continuous
Initial infusion 15 units/kg/hour based on actual body weight. Max rate: 2000 units/hour. Round off rate to nearest 50 unit/hour. Request heparin worksheet from Pharmacy based on completed order. Adjust Heparin infusion according to the dosing worksheet generated by Pharmacy. Please make changes as promptly as possible after each STAT anti-Xa level is available Routine |
| [X] heparin (porcine) injection 1,000 units/mL | IntraVENous, As needed, heparin infusion bolus
Heparin Bolus is NOT recommended in acute cerebral infarction
Dose: ________________________ Required
Heparin Bolus IV push. Max = 50 units/kg to max of 5000 units. Request heparin worksheet from Pharmacy based on completed order. Adjust Heparin infusion according to the dosing worksheet generated by Pharmacy. Please make changes as promptly as possible after each STAT anti-Xa level is available Routine |

Date:_______ Time:_______ Printed Name of Ordering Provider:__________________________________________________________________________

Provider Signature:_______________________________________________________________________________

Date:_______ Time:_______ RN Acknowledged: _______________________________________________________________________________