STROKE ALTEPLASE ORDERS - EMERGENCY DEPARTMENT

Provider to check appropriate boxes and cross out pre-checked order if not desired.
These orders are not implemented until signed by provider.

☒ Patient **weight:** _____**kg**
☒ Neuro checks: every 15 minutes starting at Alteplase bolus
☒ Vital Signs: every 15 minutes starting at Alteplase bolus
☒ Blood **pressure target is under 185/110 before Alteplase and 180/105 after Alteplase**
☒ O2 to keep SpO2 >94% or_____%
☒ Assure 2 patent large bore peripheral IVs
☒ Cardiac monitoring, continuous
☒ Full NIHSS (before Alteplase and at transfer)
☒ Administer **Alteplase as per dosing calculation below**
☒ When Alteplase bottle/minibag is empty, hang 500 mL Normal Saline on the same tubing. Set to run at same rate as Alteplase infusion and administer at least 50 mL prior to any rate change. This ensures that all Alteplase in the tubing is administered.
☒ Admission to ICU or transfer to _____.

ALTEPLASE DOSING CALCULATION: (Nursing /Pharmacy to complete)

1. Patient weight in kg_____ x 0.9 = total Alteplase dose in mg
   Total dose: ____mg (total dose may not exceed 90 mg)
2. Bolus dose is 10% of total dose given over 1 minute
   Total dose _____mg x 0.10 = ____ mg as bolus dose
3. Infusion dose is remaining 90% of total dose given over 1 hour
   Total dose ____mg - bolus dose ___mg = ___ infusion dose in mg

Dosing calculation confirmed by_____ and _____
(print/sign) (print/sign)

For acute deterioration in neurologic status or new complaint of headache during Alteplase:

☐ Stop Alteplase infusion, clamp tubing
☐ Notify provider
☐ Non-contrast head CT

For acute swelling of lips or tongue during Alteplase

☐ Stop Alteplase infusion, clamp tubing
☐ Notify provider
☐ Methylprednisolone 125 mg IV x 1
☐ Diphenhydramine 50 mg IV x 1
☐ Famotidine 20 mg/mL x1
☐ For further increase in acute swelling of lips of tongue, administer 0.3mL of 0.1% Epinephrine IV or by nebulizer

NOTE: Only marked orders will be initiated. Provider must cross out pre-checked order if not desired.

Verbal order from _____(Provider)

Nursing signature: _____

Date: _____ Time: _____

Provider signature: _____

Date: _____ Time: _____

Patient Identification

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