AUTHORIZATION IS GIVEN TO DISPENSE A GENERIC EQUIVALENT UNLESS THE PARTICULAR DRUG IS ENCIRCLED

Diagnosis: ____

Allergies: ____

Weight: ____

Physician Orders and Signature

Thrombolytic Therapy

Nursing Orders

☒ Complete consent form for Thrombolytic Therapy
☒ Place caution sign on door:
"No Veni-punctures, IM Injections or Arterial Punctures. All lab work to be done via venous access."
☒ Routine CCU orders with cardiac workup as follows:
☐ Cardiac Markers ☐ CPKMB ☐ Troponin I ☐ Myoglobin
Set 1 - on admit Set 2 - 2 – 4 hrs after admit
Set 3 – 8 hrs after admit Set 4 – 12 hrs after admit
Then daily every AM
☒ PT and APTT Stat
☒ Daily PT, APTT, and CBC while on Heparin infusion
☐ Insert Foley catheter prior to Thrombolytic Therapy
☒ Initiate Thrombolytic Infusion Flowsheet.

Medications

☒ Aspirin 325 mg crushed given orally
☒ Begin Heparin
A. Heparin 60 units/ kg (maximum 4000 units) IV bolus
B. Heparin infusion prepared as Heparin 25,000 units in 500 mL ½ normal saline (20mL per hour = 1000 units per hour)
C. Infuse at rate of 12 units /kg/hour (maximum of 1000 units/hour)
D. Do not decrease rate of Heparin infusion until 8 hours after thrombolytic is finished, unless patient is bleeding.
E. Respond to low PTTs per Heparin Protocol.

☒ Tenecteokase (TNKase)
A. Obtain patients weight. Weight = __________ kgs
B. Start 2 large bore IV sites using Y set extensions. Avoid non-compressible sites.
C. Administer TNKase _______ mg as a single bolus over 5 seconds in a line containing Normal Saline (NS) only. (Dextrose containing lines should be flushed with 10 mLs NS pre- and post TNKase)

Patient weight (lbs)	Patient Weight (kgs)	TNKase (mg)	TNKase (units)	TNKase (mLs)
< 132 lbs	**< 60 kgs**	**30**	**6, 000**	**6 mL**
≥ 132 - < 154 lbs	**≥ 60 - < 70 kgs**	**35**	**7,000**	**7 mL**
≥ 154 - < 176 lbs	**≥ 70 - < 80 kgs**	**40**	**8,000**	**8 mL**
≥ 176 - < 198 lbs	**≥ 80 - < 90 kgs**	**45**	**9,000**	**9 mL**
≥ 198 lbs	**≥ 90 kgs**	**50**	**10,000**	**10 mL**

☒ After Thrombolytic is completed flush site with 10 mLs Normal Saline.
☐ Lopressor 5 mg IV Push every 5 minutes for ☐ 1 dose ☐ 2 doses ☐3 doses
☐ Nitroglycerin infusion: Start at 10 micrograms per minute and titrate for systolic blood pressure of _____

Physician Signature: _____________________________**Date:** ____________________________

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TTPO

Thrombolytic Therapy Physician Orders (Rev. 1 4/2009)

(Revised June 2008)
Pre and Post Activase Infusion Flow Sheet. Activase Dosage Administration
Started at _______ Date______
Completed _______ Date _____
Total Activase Given __________ mg
Pt. weight ___________ kgs

Date and Time															
Initials															
Blood Pressure															
Pulse															
Respirations															
Chest pain	increased														
	decreased but present														
	same														
	absent														
EKG Arrythmias	present														
	none														
ST segment	return to baseline														
	elevated														
	depressed														
Evidence of bleeding	present														
	none														
Neuro status	normal														
	abnormal														
Skin color/temp (write in temp e.g. warm, cool, cold, diaphoretic	pink														
	pale														
	dusky														
	cyanotic														
Peripheral pulses R/L 4+ = Strong	Radial														
3+ = Normal	Brachial														
2+ = Weak	Femoral														
1+ = Intermittent	D. Pedis														
0 = Absent	P. Tibial														
Intravenous Activase insertion site	Not Bleeding														
	Bleeding														
	Swollen														
	Hematoma														

Initial	Nurse Signature * See Nurses' Notes for further discussion.
_____________	________________________________
_____________	________________________________
_____________	________________________________
______________	____________________________________

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CONSENT FOR THROMBOLYTIC THERAPY

I, ____, understand that my condition is serious and

_______________________________, M.D. /D.O., based on his assessment, findings, and my previous history, recommends thrombolytic therapy (_____________________________) as emergency treatment.

Name of Drug

I have been informed of the potential risks of complications involved with thrombolytic therapy. Major complications which may occur are:

1. Bleeding tendencies
   - A. Internal bleeding involving:
     1. Gastrointestinal tract
     2. Genitourinary tract
     3. Retroperitoneal site
     4. Intracranial site
   - B. External Bleeding
     1. Superficial surface bleeding
2. Cardiac arrhythmias

Minor complications which may occur are:

1. Nausea
2. Vomiting
3. Hypotension
4. Fever

_____I **CONSENT** to permit the initiation of thrombolytic therapy on me (or my family member.) The justifications for thrombolytic therapy and the possible complications have been explained to me.

_____I **REFUSE** to permit the initiation of thrombolytic therapy on me (or my family member.) The justifications for thrombolytic therapy and the possible complications have been explained to me.

Signature of the Patient: ______________________ Signed for Patient by: _________________________

Consent obtained by phone from: ____

Relationship: ___________________________ Reason Patient cannot sign: ________________________

Witness: ________________________ Witness: _______________________Date _______ Time______

Authorization must be signed by the patient, or by an authorized person in the case of a minor or when patient is physically or mentally incompetent.

DO NOT WRITE BELOW THIS LINE

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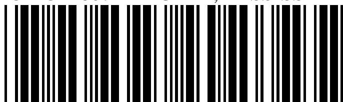

CONSENT FOR TROMBLYTIC THEAPY
TTCNT (4/2009)