

**GOALS:**

1. Reach PTT **THERAPEUTIC THRESHOLD** = 45 sec (1.5 times control) within 8 hours
2. Reach PTT **THERAPEUTIC RANGE** = 45-70 sec (1.5-2.3 times control) within 14 hours
3. Avoid PTT above 2.3 times control for greater than 24 hours

**HEPARIN TREATMENT ORDERS**

1. Patient weight in kilograms \_\_\_\_\_  
 a. **NOTE:** *If Weight greater than 100 kilograms, consider adjusting for ideal body weight*
2. Obtain PTT, PT, CBC and CREATININE before starting treatment
3. PTT 6 hours after starting treatment
4. PTT 6 hours after any dosage change
5. After obtaining two (2) consecutive therapeutic PTT, check PTT every 12 hours. If any change in treatment dose, resume previous 6 hour PTT.
6. Label all labs as STAT

**TO INITIATE THERAPY**

1. Bolus 80 units/kg = \_\_\_\_\_ units IV PUSH now
2. START INFUSION AT 18 units/kg/hour = \_\_\_\_\_ units per hour
3. **USUAL DOSE RANGE OF INFUSION = 400 units to 2,000 units/hour**  
**NOTIFY MD IF RATE OUTSIDE USUAL RANGES**

**AFTER INFUSION STARTED:**

Follow PTT results and adjust heparin infusion based on the following scale:

	BOLUS		INFUSION RATE CHANGE
PTT < 35 sec	80 units/kg bolus = _____ units IV PUSH	Give bolus then → → → → → → → →	<b>Increase</b> infusion rate by 4 units/kg/hour 4 units/kg/hr = _____ units/hour
PTT 35-59 sec	40 units/kg bolus = _____ units IV PUSH	Give bolus then → → → → → → → →	<b>Increase</b> infusion rate by 2 units/kg/hour 2 units/kg/hr = _____ units/hour
PTT 60-70 sec	0		<b>NO CHANGE</b>
PTT 71-90 sec	0	→ → → → → → → →	<b>Decrease</b> infusion rate by 2 units/kg/hour 2 units/kg/hr = _____ units/hour
PTT > 90 sec	Hold heparin 1 hour then restart infusion at reduced rate	Hold heparin then → → → → → → → →	<b>Reduce</b> infusion rate by 3 units/kg/hour 3 units/kg/hr = _____ units/hour

**NOTE: Physician / NP / PA to complete all calculations. Round to nearest whole number, when appropriate.**

Calculations completed by \_\_\_\_\_ (LIP Print Name)

RN calculations verified by: 1. \_\_\_\_\_ (RN Print Name and initial)

2. \_\_\_\_\_ (RN Print Name and initial)

**PHARMACY:** Dispense Heparin 5000 unit/ ml to patient's Pyxis Profile for bolus dosing as ordered.

**THIS FORM MUST BE SCANNED TO PHARMACY**

_____ NURSE SIGNATURE  Date: _____ Time: _____	<b>Pharmacy Scan Time:</b>  _____	Name Stamp _____ Signature _____ STAMP/PHYSICIAN SIGNATURE/BEEPER # ↓ <i>Required for countersignature on telephone/verbal orders</i> Date: _____ Time: _____
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THE GEORGE WASHINGTON UNIVERSITY HOSPITAL



PO0020

**INTRAVENOUS  
HEPARIN  
ORDERS**

Patient Label