TRANSIENT ISCHEMIC ATTACK

VTE PROPHYLAXIS ORDERS
A VTE Risk Assessment and appropriate treatment or a contraindication to treatment is required for all patients.
Patient has the following VTE Risk:
☐ Low VTE Risk (No prophylaxis needed)
☐ Moderate VTE Risk (Please Order EITHER mechanical (SCD) or pharmacological prophylaxis)
☐ High VTE Risk (Please Order BOTH mechanical (SCD) or pharmacological prophylaxis)

Contraindications
Reason for withholding Mechanical VTE prophylaxis (check one)

☐Hypervolemia	☐Congestive/Chronic heart failure	☐Sensory neuropathy
☐Edema of leg	☐Palliative care	☐Refusal of treatment by patient
☐Surgical procedure on lower extremity	☐ Injury of lower extremity	☐At risk for falls
☐Comfort measures	☐Dermatitis	☐Skin graft disorder
☐Amputee-limb	☐Peripheral ischemia	☐Peripheral vascular disease
☐Deep vein thrombosis of lower extremity	☐Deformity of leg	☐History of occlusive arterial disease of lower extremity
☐Suspected deep vein thrombosis	☐Treatment not tolerated	
	☐Vascular insufficiency of limb	

Reason for withholding Pharmacologic VTE prophylaxis (check one)

☐Blood coagulation disorders	☐Palliative care (for end of life)	☐At risk for falls
☐Bleeding or at risk for bleeding	☐Comfort measures	☐Hemorrhagic cerebral infarction
☐Renal impairment	☐Anticoagulant allergy	☐Medications refused
☐Anticoagulation not tolerated	☐Platelet count below ref	

☑ Leg compression device to be placed within 4 hours of Admission.

For Medical patient, dose should be given at 2100 daily. **Evidence
☐ Enoxaparin (Lovenox) 40 mg SubQ daily. Start today at 21:00.
Pharmacy to adjust per renal dosing protocol. May use baseline PLTS if today's PLTS not yet available.

DIAGNOSIS: Transient Ischemic Attack

ADMIT – Select Only One
REMINDER: All potential stroke patients should go to Medical Telemetry or Critical Care regardless of Admit status
☐ Place in Observation Status Reason to admit/place: _____
(The physician must document the reason for observation (INo).
☐ Admit as Inpatient. Preferred unit: __MEDICAL TELEMETRY_____
Reason to admit: _____
(The physician must document the reason for inpatient).

CODE STATUS
REMINDER**:** For DNAR status complete separate DNAR Physician Order Set

SKIN TREATMENT AND PREVENTION
☑ Initiate designated skin set: If Braden score of 18 or less initiate Skin Treatment and Prevention short set. For other any skin issues initiate designated skin order set(s).

NURSING
☑ Initiate full NIH Stroke Scale on admission, Q shift, and on discharge
☑ Orthostatic blood pressure (BP) prior to first time getting out of bed

☑ Notify Neurologist (or if no neurologist then attending) if:
- •change in neuro status,
- •change in level of consciousness,
- •change in pupil size/reactivity,
- •worsening headache,
- •unexplained vomiting,
- •increased agitation

☑ Notify MD of abnormal vital signs (VS)
- •if respiratory rate < 8/min or > 24 /min
- •if oxygen saturation is < 92%

☑ RN bedside swallow screen on admission prior to any PO intake Evidence
☐ Blood glucose monitoring (BGM) one time only on admission.
If > 150 mg/dL, notify MD to initiate SubQ Insulin SS.
☐ Blood glucose monitoring (BGM)-AC and HS
☐ Blood glucose monitoring (BGM)-Q 6 hours if patient NPO. Recommended schedule: 0745,1100,1700,2100
☐ Insert post pyloric tube
☐ Insert nasogastric/orogastric tube
☐ Aspiration precautions
☑ Apply telemetry monitoring
☐ May leave floor without telemetry monitor

ACTIVITY
REMINDER: If there are no restrictions nursing will ambulate the patient at least four times a day per policy PC-112
☑ Head of bed (HOB) at 90 degrees while eating when patient no longer NPO
☐ Elevate head of bed (HOB) at 30 degrees and keep head midline

RESPIRATORY
☑ Apply oxygen (O2) with defined parameters to maintain oxygen saturation on > 92%
☐ Continuous pulse oximetry

NUTRITION
☑ NPO until swallow screen/evaluation
☐ Cardiac 2 Gm Sodium Diet
☐ Diabetic 1800 Calorie Diet
☐ Diabetic 2200 Calorie Diet

IV FLUIDS
☐ Sodium Chloride 0.9% IV to run at 100 mL/Hr.
☐ Saline lock IV if tolerating Po fluids, Temp < 100.4º F, HCT > 30, and PCA not required. Saline Flush 2 mL IV Push Q 8 Hrs and after each IV medication dose. RN to contact Pharmacy to DC IV Fluid order(s) when IV Fluid is converted to saline lock.

MEDICATIONS
Analgesic/Antipyretic medications: Mild Pain/HA/Fever
☐ Acetaminophen (Tylenol) 650 mg Po Q 6 Hrs Prn mild pain (scale 1-3) or Temp > 99.6 ºF or 37ºC.
Total acetaminophen not to exceed 4,000 mg/24 Hrs.
☐ Acetaminophen (Tylenol) liquid 650 mg NG Q 6 Hrs Prn mild pain (scale 1-3) or Temp > 99.6 ºF or 37ºC.
If patient is unable to take Po acetaminophen (if ordered) and has an NG tube.
Total acetaminophen not to exceed 4,000 mg/24 Hrs.
☐ Acetaminophen (Tylenol) Supp 650 mg PR Q 6 Hrs Prn mild pain (scale 1-3) or Temp > 99.6 ºF or 37ºC.
If patient is unable to take Po/NG acetaminophen (if ordered).
Total acetaminophen not to exceed 4,000 mg/24 Hrs.

Anticoagulant medications: LMWH's/UFH (treatment doses)
REMINDER: Use anticoagulant medications for the treatment of Atrial Fibrillation to reduce the risk of recurrent stroke if there are no Contraindications to anticoagulation.
☐ Enoxaparin (Lovenox) 1 mg/Kg = _____mg SubQ Q 12 Hrs. Pharmacy to adjust per renal dosing protocol. Indication: AFib/Stroke
☐ Heparin drip per pharmacy protocol. No bolus. Goal APTT = 55-75 sec Indication: AFib/Stroke.

Anticoagulant medications: Vitamin K antagonists Evidence
REMINDER: For patients with cerebrovascular disease (e.g. history of TIA or stroke) associated with nonrheumatic atrial fibrillation, atrial flutter, or prosthetic heart valves, administer a vitamin K antagonist Evidence
REMINDER: For patients with noncardioembolic TIA or ischemic stroke who have no other indications for anticoagulation, do not use warfarin Evidence
☐ Warfarin (Coumadin) per pharmacy protocol. Indication: AFib/Stroke Goal INR= 2-3

Anticoagulant medications: Platelet Inhibitors (Salicylate) ***Physician to select ONE dose only*** Evidence
REMINDER: Aspirin should be administered by end of hospital day 2 and prescribed upon discharge for patients who do not have an indication for warfarin Evidence
REMINDER: Avoid the routine addition of aspirin to clopidogrel Evidence
REMINDER: For patients with a noncardioembolic TIA or ischemic stroke, use the combination of aspirin and extended-release dipyridamole rather than aspirin alone Evidence
☐ Antithrombotic contraindicated:
Reasons to withhold Antithrombotic agents
- ☐ Allergy to or complication related to antithrombotic
- ☐ Rule out bleed
- ☐ Intolerance in past
- ☐ Intracranial surgery/biopsy
- ☐ Planned surgery
- ☐ Hemorrhage
- ☐ Bleeding risk
- ☐ Bleeding disorder
- ☐ Peptic ulcer disease
- ☐ Other:_____

☐ Aspirin 325 mg Po daily once cleared by bedside swallow screen. RN to contact pharmacy to enter Aspirin 325 mg NG daily order if pt unable to take Po and has an NG tube. RN to contact pharmacy to enter Aspirin suppository 300 mg PR daily order if pt unable to take Po/NG.
☐ Aspirin 162 mg Po daily once cleared by bedside swallow screen. RN to contact pharmacy to enter Aspirin 162 mg NG daily order if pt unable to take Po and has an NG tube. RN to contact pharmacy to enter Aspirin suppository 150 mg PR daily order if pt unable to take Po/NG.
☐ Aspirin 81 mg Po daily once cleared by bedside swallow screen. RN to contact pharmacy to enter Aspirin 81 mg NG daily order if pt unable to take Po and has an NG tube. RN to contact pharmacy to enter Aspirin suppository 150 mg PR daily order if pt unable to take Po/NG.

Anticoagulant medications: Platelet Inhibitors (Combination Agents) Evidence (214290)
☐ Aggrenox (aspirin 25 mg / dipyridamole 200 mg) 1 tablet Po BID.

Anticoagulant medications: Platelet Inhibitors (Thienopyridines) Evidence (214291)
REMINDER - A thienopyridine should be administered within 48 hours of admission and prescribed upon discharge for patients who do not have an indication for warfarin and who have a contraindication to aspirin Evidence (214291)
☐ Clopidogrel (Plavix) 300 mg Po x 1 dose now as a loading dose.
☐ Clopidogrel (Plavix) 75 mg Po daily. Start 24 Hrs after 300 mg dose (if ordered).

Cardiac medications: Anti-hypertensives
☐ LaBETalol (Trandate) 20 mg IV Push over 2 mins Q 10 mins Prn SBP > 220 or DBP > 120. If SBP remains > 220 or DBP remains > 120 after 60 mg (3 doses), contact MD for alternative orders. Hold for HR < 50 and notify MD. Maximum total dose = 300 mg/24 Hrs.
☐ HydrALAZINE (Apresoline) 10 mg IV push over 2 mins Q 1 Hr Prn SBP > 220 or DBP > 120 if unable to

give laBETalol. ** For Critical Care, Med Tele, and Cardiac Renal use only. DC when transferred out of these units.**

Cardiac medications: Statins
☐ Statin Contraindication
Reasons to withhold Statin therapy

☐ Hepatic Failure	☐ Inflamatory Disease of liver	☐ No evidence of atherosclrosis
☐ Palliative Care	☐ Patient in Clinical Trial	☐ Medical Contarindication
☐ Patient refuses Treament	☐ Rhabdomyolysis	☐ Statin Not Tolerate

☐ Simvastatin (ZoCOR) 20 mg Po daily in the evening

GI medications: Anti-emetics
☐ Ondansetron (Zofran) 4 mg IV Push Q 12 Hrs Prn N&V. May give IM if no IV access. If ineffective after 30 mins, give proCHLORperazine if ordered.
☐ ProCHLORperazine (Compazine) 10 mg IV Push Q 6 Hrs Prn N&V. If ondansetron Prn is also ordered, give ondansetron first. If ondansetron ineffective after 30 mins, give proCHLORperazine as ordered. May give IM if no IV access.

GI medications: Stress Ulcer Prophylaxis/Antacids *Physician to select ONE order only*
☐ Famotidine (Pepcid) 20 mg Po BID. RN to contact pharmacy to enter IV order if pt unable to take Po. Pharmacy to adjust per renal dosing protocol.
☐ Famotidine (Pepcid) 20 mg IV Push BID. RN to contact pharmacy to enter Po order when pt is able to take Po. Pharmacy to adjust per renal dosing protocol.

GI medications: Laxatives/Stool Softeners/etc
☐ Docusate sodium (Colace) 100 mg Po BID. Hold for loose stools.
☐ Maalox Plus (aluminum/magnesium/simethicone) 30 mL Po Q 4 Hrs Prn indigestion. (product contains magnesium salt)
☐ Milk of Magnesia (MOM) 30 mL Po Q 6 Hrs Prn constipation. (product contains magnesium salts).
☐ Bisacodyl (Dulcolax) suppository 10 mg PR daily Prn constipation if Milk of Magnesia (MOM) (if ordered) not effective.
☐ Fleet enema adult 1 bottle (133 mL) PR daily Prn constipation if Milk of Magnesia (MOM) (if ordered) and Bisacodyl (Dulcolax) (if ordered) not effective. (product contains phosphate salts)

Endocrine medications: Diabetic Therapy
REMINDER - For Subcutaneous Insulin Orders - Use Subcutaneous Insulin Short Set/Order Form

Other medications:_____

***All labs/diagnostics will be drawn/done routine now unless otherwise specified**

LABORATORY - Cardiac Markers
☐ Troponin-I (TROP)- In AM

LABORATORY - Hematology
☐ Complete blood count (CBC) - In AM
☐ Erythrocyte Sedimentation Rate (ESR) - In AM

LABORATORY - Chemistry
☑ Lipid Profile (LPP) - In AM Evidence
☐ Basic Metabolic Panel (BMP) - In AM
☐ Chemistry Panel Comprehensive (CMP) - In AM
☐ C Reactive Protein (CRP) - In AM
☐ Hemoglobin A1c - In AM

☐ Homocysteine, serum - In AM
☐ Thyroid Stimulating Hormone (TSH) - In AM

LABORATORY – Immunology
☐ Anti Nuclear Antibody (ANA) - In AM

LABORATORY - Serology
☐ Rapid Plasma Reagin (RPR) - In AM

DIAGNOSTICS – Cardiology
REMINDER: Review imaging results prior to ordering additional studies to prevent duplication
REMINDER: A carotid imaging study to evaluate for internal carotid stenosis should be preformed
REMINDER: If CTA or MRA of the neck has been performed a carotid ultrasound is not indicated
☐ Electrocardiogram (12-lead EKG); Reason: Transient Ischemic Attack Evidence
☐ Echocardiogram, transthoracic; Reason: Transient Ischemic Attack Evidence

DIAGNOSTICS - Radiology
☐ Chest x-ray 1 View (CXR) Portable; Reason: _____
☐ Chest x-ray 2 View (CXR); Reason:_____

DIAGNOSTICS - CT
☐ CT Angiography, neck with and without contrast. Reason: Transient Ischemic Attack Evidence
☐ CT brain with and without contrast. Reason: Transient Ischemic Attack

DIAGNOSTICS - MRI
REMINDER: If CT Angio of the brain/head was already done in ED MRA of the neck may not be indicated
☐ MRI Angiography, cerebral without contrast. Reason: Transient Ischemic Attack Evidence
☐ MRI Angiography neck carotid without contrast. Reason: Transient Ischemic Attack Evidence
☐ MRI brain without contrast. Reason: Transient Ischemic Attack Evidence

DIAGNOSTICS - Ultrasonography
REMINDER: If CT Angio of the brain/head was already done in ED carotid ultrasound may not be indicated
☐ VIH Carotid Doppler Ultrasound bilateral; Reason: Transient Ischemic Attack Evidence

MD CONSULTS
REMINDER: Consider Specialty Referral (i.e. Neurology, Cardiology) Evidence
☐ Consult MD_____
☐ Consult MD_____
☐ Consult MD_____

REQUEST FOR SERVICE
☑ Consult Physical Therapy evaluation and treatment for strengthening and mobility
☑ Outpatient Physical Rehabilitation Referral
☐ Consult for Occupational Therapy evaluation and treatment for activities of daily living (ADLs)
☐ Consult Speech Therapy for swallow evaluation and treatment
☐ Consult Speech Therapy for speech evaluation and treatment
☐ Consult for Nutritional Services Evidence
☐ Consult for Case Management
☐ Consult for Social Services