Vancouver CoastalHealth
VGH / UBCH / GFS

PHYSICIAN'S ORDERS

ADDRESSOGRAPH

HEPARIN/WARFARIN STANDARDIZED PROTOCOL

(Items with tick boxes must be selected to be ordered)

Date: _____ Time: _____

1. Patient weight: _____kg.
2. No intramuscular injections.
3. If possible, avoid non-steroidal anti-inflammatory drugs (NSAIDs).
4. Laboratory: Baseline PTT, INR and CBC with platelet count
   CBC with platelet count on day 1, then Q2days while on heparin
   INR daily when initiating warfarin
5. Discontinue previous heparin and low molecular weight heparin orders
6. a) **INITIAL HEPARIN THERAPY**
   Heparin IV bolus and initial infusion (using 25,000 units heparin/500 mL=50 units/mL) as below:

Patient Wt (Kg)	Heparin IV Bolus (units)	Initial Infusion	
☐ less than or equal to 50	4,000	750 units/hour	= 15 mL/hour
☐ 51 to 60	5,000	1,000 units/hour	= 20 mL/hour
☐ 61 to 70	6,000	1,100 units/hour	= 22 mL/hour
☐ 71 to 90	7,000	1,300 units/hour	= 26 mL/hour
☐ 91 to 105	8,000	1,450 units/hour	= 29 mL/hour
☐ greater than 105	9,000	1,650 units/hour	= 33 mL/hour

   b) **PTT-ADJUSTED HEPARIN THERAPY**
   ‡PTT in 6 hours, then adjust heparin infusion and repeat PTT per sliding scale below:
   *****CALL PHYSICIAN IF 3 CONSECUTIVE PTTs < 50 SEC OR > 140 SEC*****

PTT (sec)	BOLUS DOSE IV	STOP INFUSION	RATE CHANGE (50 units/mL)	‡REPEAT PTT
< 50	5,000	0	+3 mL/hour (increase by 150 units/hour)	6 hours
50 to 59	0	0	+2 mL/hour (increase by 100 units/hour)	6 hours
60 to 120 (Therapeutic)	0	0	0 (no change)	Next day
121 to 130	0	0	-1 mL/hour (decrease by 50 units/hour)	6 hours
131 to 140	0	30min	-2 mL/hour (decrease by 100 units/hour)	6 hours
> 140	0	60 min	-4 mL/hour (decrease by 200 units/hour)	6 hours

   ‡ **specify on lab requisition "STAT PTT"**

7. **WARFARIN THERAPY**
   ☐ Warfarin _____mg PO daily x 2 days to start on _____.
   (warfarin to be ordered on a daily basis thereafter)
8. Discontinue heparin after at least 5 days of combined heparin/warfarin therapy when INR greater than 2.0 for 2 consecutive days (Physician order required).

_____ _____
Physician Signature Printed Name/PIC

*HPW Rev. Apr-07

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