Oxford University Hospitals NHS
NHS Trust

OUH VTE Assessment down time form - Medical Patient

Date/time assessment completed:
Name:
Grade/Position:
Patient Location:

Affix patient ID label here

Is the patient on therapeutic anticoagulation e.g. warfarin with an INR > 2.0, therapeutic dose LMWH or unfractionated heparin infusion?

Yes ☐ *If yes, refer to guidance note **1b*** No ☐

Patient Type

Medical: Reduced Mobility ☐
'A medical patient who is expected to have significantly reduced mobility relative to normal state'

Medical: Normal Mobility ☐ *if normal mobility patient, refer to guidance note **1b***
'A medical patient who is NOT expected to have significantly reduced mobility relative to normal state'

Palliative Care Pathway?

Yes ☐ *If 'Yes', complete the assessment as usual but carefully consider whether the interventions are appropriate given the patient's pathway* No ☐

Thrombosis Risk

None of the following apply	☐	*refer to guidance note 1b*
Age over 60	☐	
Active cancer or cancer treatment	☐	
Dehydration	☐	
Known Thrombophilias	☐	
Obesity: BMI > 30	☐	
One or more significant medical co-morbidities *e.g. heart disease; metabolic , endocrine or respiratory pathologies; acute infectious diseases or inflammatory conditions*	☐	
Personal history or first-degree relative with a history of VTE	☐	
Use of hormone replacement therapy	☐	
Use of oestrogen-containing contraceptive therapy	☐	
Pregnancy or < 6 weeks post-partum *see NICE guidance for specific guidance*	☐	
Varicose veins with phlebitis	☐	
Significantly reduced mobility for 3 days or more	☐	
Hip or knee replacement or join fracture	☐	
Total anaesthetic + surgical time > 90 mins	☐	
Active cancer or cancer treatment	☐	
Surgery involving pelvis or lower limb with a total anaesthetic + surgical time > 60 mins	☐	
Acute surgical admission with inflammatory or intra-abdominal condition	☐	
Critical care admission	☐	
Surgery with significant reduction in mobility	☐	

Bleeding Risk

None of the following apply	☐	*refer to guidance note* ***2b***
Active Bleeding	☐	
Acquired bleeding disorders (e.g. acute liver failures)	☐	
Concurrent use of anticoagulants known to increase risk of bleeding (such as warfarin with INR > 2)	☐	
Acute stroke	☐	
Thrombocytopenia (<75 x 10E9/l)	☐	
Uncontrolled systolic hypertension (230/120 mmHg or higher)	☐	
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrand's disease)	☐	
Neurosurgery, spinal surgery or eye surgery	☐	
Other procedures with high bleeding risk	☐	
Lumbar puncture/epidural/spinal anaesthesia within the next 12 hours	☐	
Lumbar puncture/epidural/spinal anaesthesia within the previous 4 hours	☐	

Contraindications to anti-embolism stockings

None of the following apply *refer to guidance note* ***4b***	☐
Peripheral neuropathy *refer to guidance note* ***5b***	☐
Peripheral Vascular Disease *refer to guidance note* ***5b***	☐
Gross oedema *refer to guidance note* ***5b***	☐
Leg deformity *refer to guidance note* ***5b***	☐
Acute Stroke (consider using IPC devices) *refer to guidance note* ***5b***	☐

Guidance

1b. Risk assessment now complete. No thromboprophylaxis required. Continue to review and re-assess as clinical condition changes.

2b. Start dalteparin 5000 Units S/C daily (NB caution in renal failure where GFR<20mls/min, anti-Xa monitoring is recommended if LMWH is to be used for more than 10 days). Continue until patient is mobile or discharged.

3b. Offer mechanical VTE prophylaxis on admission unless contra-indicated. Start dalteparin or other approved drug. Refer to BNF/local policies for dose and peri-operative use. If major cancer surgery in the abdomen or pelvis continue for 28 days.
For hip fractures or replacement continue for 28-35 days. For knee replacement continue for 10-14 days.

4b. Offer mechanical thromboprophylaxis e.g. anti-embolic stockings.
Continue to review and re-assess as clinical condition changes

5b. Discuss the risks and benefits of offering either mechanical or pharmacological thromboprophylaxis with your consultant. Document the decision in the patient's medical notes. Continue to review and re-assess as clinical condition changes.