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| **Urgent Suspected DVT Referral Form**  **Email completed form to:** [**rch-tr.ThrombosisNurses@nhs.net**](mailto:rch-tr.ThrombosisNurses@nhs.net)  **PLEASE NOTE THIS FORM WILL BE RETURNED TO THE REFERRING CLINICIAN IF IT IS NOT COMPLETED IN FULL** | | | | | | | | | | | | | | | | |
| **Patient Details** | | | | | | **Referrer Details** | | | | | | | | | | |
| **Name:** | | | Click here to enter text. | | | **Name:** | | Click here to enter text. | | | | | | | | |
| **Address:** | | | Click here to enter text. | | | **Job title:** | | Click here to enter text. | | | | | | | | |
| **DOB:** | | | Click here to enter text. | | | **GP name:** | | Click here to enter text. | | | | | | | | |
| **NHS No.** | | | Click here to enter text. | | | **GP surgery:** | | Click here to enter text. | | | | | | | | |
| **Contact telephone number for patient:**  Click here to enter text. | | | | | |  | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **Date of onset of symptoms** | | | | **Assessment time/date** | | | | | **Referral time/date** | | | | | | | |
| Click here to enter a date. | | | | Hour | Min | | Date | | Hour | Min | | | | Date | | |
| **PLEASE NOTE: This form should only be used for patients with acute DVT symptoms. Patients with symptoms >4 weeks duration should be referred directly to Vascular Studies Unit via the non-urgent referral pathway unless discussed with Thrombosis Nursing Team directly** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | **Box 1. Wells Pre-test probability Score**  **(to be completed for all patients except pregnancy (see Box 2) or patients already formally anticoagulated (see Box 3)** | | | | | | | | | | | | **Points** | | **Score** |  | |
|  | **Active cancer (treatment ongoing, within 6 months, or palliative)** | | | | | | | | | | | | **+1** | | Select |  | |
|  | **Paralysis, paresis or recent plaster immobilisation of the lower extremities** | | | | | | | | | | | | **+1** | | Select |  | |
|  | **Recently bedridden for 3 days or more or major surgery within 12 weeks requiring general or regional anaesthesia** | | | | | | | | | | | | **+1** | | Select |  | |
|  | **Localised tenderness along the distribution of the deep venous system** | | | | | | | | | | | | **+1** | | Select |  | |
|  | **Entire leg swollen (objectively measured increased swelling at both calf and thigh)** | | | | | | | | | | | | **+1** | | Select |  | |
|  | **Calf swelling at least 3 cm larger than asymptomatic side**  **(if this option is selected indicate calf sizes (cm) in the boxes to the right)** | | | | | | | | | | | | **+1** | | Select |  | |
|  | **LEFT RIGHT** | | |  | |
|  | Size. | | Size. |  | |
|  | **Pitting oedema confined to the symptomatic leg** | | | | | | | | | | | | **+1** | | Select |  | |
|  | **Collateral superficial veins (non-varicose)** | | | | | | | | | | | | **+1** | | Select |  | |
|  | **Previously documented DVT** | | | | | | | | | | | | **+1** | | Select |  | |
|  | **An alternative diagnosis is at least as likely as DVT (Consider alternative diagnosis - Cellulitis, Baker’s Cyst, Oedema, Post-thrombotic syndrome, trauma)** | | | | | | | | | | | | **-2** | | Select |  | |
|  | **Score 2 or More – DVT Likely/Score 1 or Less - DVT Unlikely** | | | | | | | | | | | | | | Select |  | |
|  |  |
| **D-dimer result (please indicate if negative or positive)**  **(D-dimer not indicated if Wells score is likely and not valid in pregnancy)** | | | | | | | | | | | **Negative** | | | | | |
| **Positive** | | | | | |
| **Not done** | | | | | |
| **Please indicate which leg you would like to be scanned**  **NB Bilateral DVT is clinically rare - bilateral swelling is more likely due to an alternative diagnosis (heart failure, dependant oedema)** | | | | | | | | | | | Select leg. | | | | | |
| **Please indicate level of mobility of patient** | | | | | | | | | | | **Walking** | | | | | |
| **Chair** | | | | | |
| **Stretcher** | | | | | |
| **BOX 2. Patients who are pregnant:** | | | | | | | | | | | | | | | | |
| **D-dimer testing is not indicated in pregnancy - all patients require doppler scanning – please indicate current gestation of patient here:** | | | | | | | | | | | Click here. | | | | | |
| **BOX 3**. **Patients already receiving anticoagulation:** | | | | | | | | | | | | | | | | |
| **New VTE events are very unlikely in patients who are already therapeutically anticoagulated in the absence of underlying malignancy. GPs should consider the possibility of non-concordance with medications including reviewing previous INR results as well as checking an up-to-date INR in patients who are Warfarinised, prior to making a referral. If DVT remains most likely diagnosis the patient’s current oral anticoagulation should be switched to treatment dose LMWH daily until ultrasound scanning has been performed** | | | | | | | | | | | | | | | | |
| **Please indicate if this patient is currently anticoagulated?** | | | | | | | | | | | | Select | | | | |
|  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **BOX 4. Further relevant additional information (ie summary of history, event details, current medications including any anticoagulation treatment commenced whilst awaiting Doppler scan)** | | | | | | | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | | | | | | | |