

 **DVT Service – Referral form**

**Personal Details**

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|  Patient name: |  | Date of Birth: |  |
| NHS Number: |  | Date of referral |  |
|  Patient Mobile Tel: |  | Patient Home Tel: |  |
|  Home Address: |  |
|  Registered Practice: |  | Referring GP / Clinician: |  |
|  Practice Tel No: |  |   |  |
|  **CONSENT**: Has the patient consented to record sharing with Cohese Healthcare (for the purpose of direct provision of care, and for this service only)? | Yes/No |
| Patient has had DVT diagnosed elsewhere, within past month, and is being referred for follow up only? Yes please give details No please continue to complete form below |
| **Patient Presenting with**;***(State leg & circle symptoms as appropriate):*** | **Which leg?** | Painful | Red | Swollen |
| Duration of symptoms | ≤ 2 weeks | 2-4 weeks | 5-8 weeks | ≥ 8 weeks |

|  |  |
| --- | --- |
| Patient is mobile and can get on/off examination bed with minimal assistance **Yes / No** | **If No** is hoist required **Yes / No** |
| Patient has active cancer? **Yes / No** | CKD 4 **Yes / No** |
| Is the patient pregnant/postpartum? **Yes / No** | Weight: kg Date:  |
| Is the patient on long term anticoagulation? | **Yes / No** | **If yes, drug name and dosage:** |
| Which anticoagulant do you feel patient would be most suitable for? | **Apixaban** | **Rivaroxaban** | **LMWH** | **Warfarin** |
| Please advise if patient has any additional needs? | Sight impairment | Hearing impairment | Speech impairment | Dementia |
| Learning disability | Mental health concern | Physical disability | Progressive condition |
| Does the patient require an interpreter? | **Yes / No** | Please give details: |

**Wells Score / D-dimer Test for all appropriate patients** (D dimer not appropriate during pregnancy or after recent childbirth, surgery, trauma, or an infection, if symptoms for more than 2 weeks or if superficial vein thrombus (not DVT) suspected.)

|  |  |
| --- | --- |
| Wells score | D dimer result Date |

**Pre-Scan Anti-Coagulant prescribed** (Please supply enough for 7 days)

|  |  |  |
| --- | --- | --- |
| **Drug - name** | NB. Edoxaban requires 5 day lead in with LMWH | **Dose:** |
| **Reason for no anticoagulation** |  |
| **If patient also taking antiplatelet medication is this to continue with anticoagulation? Yes / No / N/A** |

Once completed please send via **EMIS Managed Referral** to **Cohese Healthcare** or Email cohese.dvt@nhs.net.