

**Personal Details**

**DVT Service - Patient Record Card**

**FOR COMPLETION BY REFERRER**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 GP Care (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 | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | |
| What is the patient’s main spoken language? | | | | | | |  | | | | | | | |
| 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 **GP Care** or Email [gpcare.dvt@nhs.net](mailto:gpcare.dvt@nhs.net).