GP DVT Diagnostic Pathway Assessment and Referral Form: Waikato DHB

Initial Consultation Date/Time:

Patient Details

NHI:

Given name: Surname:

DOB: Sex: Ethnicity:

Address:

Day Ph: Alternate Ph: Mobile:

Referrer Details

GP Name: NZMC No:

Address:

Ph: Fax:

Patient's usual GP:

Referring GP signature:

For full GP DVT Diagnostic Pathway protocol details online refer to www.waikatodhb.govt.nz/GP.

DO NOT use this form if patient ACC, pregnant or up to 4 weeks post-partum. Follow normal referral process in these cases.

Modified Wells Criteria	Score (circle)		Score (circle)
• Active cancer (treatment in past 6/12 or palliative)	+1	• Pitting oedema confined to symptomatic leg	+1
• Paralysis, paresis or recent plaster immobilisation of lower leg	+1	• Distended non-varicose superficial veins on symptomatic side	+1
• Recent immobilisation > 3 days, or major surgery < 12 weeks	+1	• Previously documented DVT	+1
• Localised tenderness along the distribution of the deep veins	+1	• Entire leg is swollen	+1
• Calf swelling > 3cm difference from asymptomatic side (Measure at 10cm below the tibial tuberosity)	+1	• Is alternative diagnosis as, or more likely than DVT	subtract 2

Total Score: Note: If score is 1 or less, order D-dimer (low risk); If score is 2 or more, refer for ultrasound (high risk).

Enoxaparin administered: Y / N (circle one)

Date adminstered: Dose: Time:

D-dimer Result **Date:** **Positive:** **Negative** (Circle one)

Ultrasound Referral **Appt Date:** **Time:** **Place:**

Please ultrasound right/left (Circle one) lower limb as per GP DVT Diagnostic Pathway protocol

First referral/Follow-up referral (Circle one) Note: Follow up USS at 1 week if Wells >=2 with USS neg and pos D-dimer

Ultrasound Result: **Positive:** **Negative** (Circle one)

Note: Please attach preliminary report if positive and refer to ED as per GP DVT Diagnostic Pathway protocol

Anglesea Clinical Exceptional Circumstances Referral refer for Enoxaparin administration if DVT suspected and > 6 hr wait for D-dimer or USS)

Note: Only to be used if GP unable to administer this themselves. i.e. under exceptional circumstances.

Please administer this patient Enoxaparin as per the GP DVT Diagnostic Pathway protocol provided there are no contraindications.

Date administered: Dose: Time:

ED Referral for confirmed DVT

This patient has a right / left (Circle one) deep vein thrombosis confirmed on ultrasound examination.
Thank you for further management as appropriate. Relevant additional clinical details overleaf.

Signed: (ULTRASOUND PROVIDER)

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Additional Patient Information for ED DVT Referral

Patient Details

NHI:

Given name: Surname:

Address:

DOB: Sex: Ethnicity:

Day Ph: Alternate Ph:

Referrer Details

GP Name: NZMC No:

Address:

Ph: Fax:

Patient's usual GP:

Current Medications:

Medication Alerts:

Relevant Medical History: (Particularly any contraindications to anticoagulant therapy)