VTE ADMISSION ORDER

☐ 1ST Assessment ☐ 2nd Assessment	☐ Preoperative	☐ Transfer to ICU	☐ Change in patient condition
	☐ Complications of Thrombo-prophylaxis		☐ Others

Attending Physician		**Diagnosis**			
Assessment Date/Time		**Assessed By**		**ID**	

1. What is the patient's Risk Score for VTE?

3 Risk Points		2 Risk Points		1 Risk Points	
☐	Past history of VTE	☐	Age > 65y with restricted mobility	☐	Age 40 - 65y with restricted mobility
☐	Ischemic stroke with paralysis	☐	Myocardial infarction	☐	Infections/acute inflammatory disease without bed rest
☐	Acute respiratory failure with mechanical ventilation	☐	CHF (NYHA III OR IV)	☐	Central venous access
☐	Thrombophilia#	☐	Severe respiratory disease without mechanical ventilation	☐	Dehydration
☐	Acute spinal cord injury*	☐	Infection/acute inflammatory disease with bed rest	☐	Polycythemia or thrombocytosis
☐	Multiple trauma*	☐	Sepsis	☐	Hormone therapy / Oral contraception
☐	Hip, Pelvis or leg fracture*	☐	Active malignancy / cancer treatment	☐	Pregnancy/postpurperium 1 month
☐	High risk surgery	☐	Nephrotic syndrome	☐	Obesity
	Major Joint Replacement	☐	Myeloproliferative disorder	☐	Burns
	Hip fracture surgery	☐	Immobilizing Plaster Cast	☐	Varicose veins
	Major Cancer Surgery	☐	Major surgery:	☐	Malignancy within 5y
			Lasting more than 45 mins	☐	History of major surgery in 6 m
			*Open abdominal, Gynecologic or Urologic surgery, Cranial and spinal neurologic surgery**	☐	Non-major surgery
				☐	Paroxysmal Nocturnal Hemoglobinurea
Total		Total		Total	
Grand Total					

**** Risk of bleeding should be thoroughly assessed***

2. According to your assessment, check the Protocol you recommend:

☐ **Low Risk Patient (1 Point):** Patient education + Early ambulation
□ Optimal GCS

☐ **Moderate Risk Patient (2 Points):** Patient education + Early ambulation + Pharmacologic Prophylaxis
□ Optimal Mechanical Prophylaxis (SCD or AVI or GCS)

☐ **High Risk Patient (3 Points or more):** Patient education + Early ambulation + Pharmacologic Prophylaxis + Optimal Mechanical Prophylaxis (SCD or AVI or GCS)

☐ **Contraindications to pharmacologic prophylaxis** [table 2] **with Risk Score ≥ 2**: Patient education + Early ambulation + Optimal Mechanical Prophylaxis (SCD or AVI or GCS)

3. Ambulation Protocol: (Start time, frequency, with oxygen?)

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4. Pharmacologic prophylaxis [table 3] (Start time, dose, frequency, laboratory tests, end time and post discharge prophylaxis)

R/……

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5. Reasons if thrombo-prophylaxis was not implemented:

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Table (1) : Contraindications to Mechanical Devices	Table (2): Contraindications and Precautions to Pharmacologic Prophylaxis
☐ Suspect DVT	☐ Active bleeding
☐ Delayed Application (r/o DVT first by Doppler U/S)	☐ Hemorrhagic stroke
☐ Peripheral ischemic vascular disease	☐ Bleeding tendency
☐ Recent skin graft	☐ PLT count _<50,000/mm3
☐ Gross edema of legs in CHF	☐ Uncontrolled hypertension (>200/120)
☐ Pressures sores to heels/insensitive extremities	☐ Dissecting aneurysm of the aorta
☐ Cellulitis/ Dermatitis/ phlebitis	☐ Bacterial endocarditis
☐ Extreme deformity of lower limbs/ fragile skin	☐ Active hepatitis or hepatic insufficiency
☐ Others (specify): ……	☐ Hypersensitivity to drugs
	☐ History of HIT (contraindication to heparins)#
	☐ Surgical procedures with high risk of bleeding*
	☐ Spinal tap or epidural anesthesia*
	☐ Severe renal insufficiency
	☐ Others (specify): ……

Table: 3

High Risk (no adjustment)*	Moderate Risk (no adjustment)*
☐ **Enoxaparin** 40 mg every 24 hours.	☐ **Enoxaparin** 30 mg subcutaneously every 24 hours.
☐ **Enoxaparin** 30 mg subcutaneously every 12 hours (e.g. In Trauma and SCI).	☐ **Enoxaparin** 40 mg subcutaneously every 24 hours.
☐ **LDUFH** 5000 unit subcutaneously every 8 hours	☐ **LDUFH** 5000 unit subcutaneously every 12 hours

☐ **Fondaparinux (Arixtra)** 2.5 mg subcutaneously every 24 hours* is indicated for thrombo-prophylaxis in HIP Fracture Surgery, Knee Replacement Surgery and Hip Replacement Surgery.

* Regimens are for guidance only: The caring physician should weigh risk and benefit for each patient.
* Refer to Clinical Pharmacist for Dose Adjustment in severe renal impairment (Creatinine clearance ≤ 30 ml/min) and pediatric cases (i.e. For Enoxaparin **no dose** adjustment is needed in mild & moderate renal impairment. However, in severe renal impairment dose reduction to 30 mg or 20 mg every 24 hours is recommended).

Doctor's Name	Dr. No.	Signature	Date/Time

References:

1. Prevention of Venous Thromboembolism. The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Chest, 2004:126:338S - 400S.
2. Geerts, W.H., et al., Prevention of venous thromboembolism: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition). Chest, 2008. **133**(6 Suppl): p. 381S-453S.
3. Venous Thromboembolism Prophylaxis. Institute for Clinical Systems improvement. 3rd edition/2006 www.icsi.org.
4. Capri et al: Effective Risk Stratification or Surgical and Nonsurgical Patients for VTE. Seminar in Hematology Vol.38 No.2,Suppl 5, April 2001.
5. Motte et al: Prevention of Postoperative Venous Thromboembolism Risk Assessment and Methods of Prophylaxis. CAN J. ANESTH 2006 / 53:6/ pp S68-S79.
6. Rashid et al: Venous Thromboprophylaxis in UK Medical Inpatients. J R. Soc. Med. 2005 98: 507-512.

- **VTE**: Venous Thrombo-Embolism
- **LMWH**: Low Molecular Weight Heparin
- **AVI**: Arterio-Venous Impulse
- **HIT**: Heparin Induced Thrombocytopenia
- **VTEP**: Venous Thrombo-Embolism Prophylaxis
- **LDUFH**: Low Dose Unfractionated Heparin
- **SCD**: Sequential Compression Device. CGS: Graduated Compression Stockings
- **CHF**: Congestive Heart Failure.