

# 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](http://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).

## 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  $\geq 2$  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 Clinic Referral (refer for Enoxaparin administration if DVT suspected and > 6 hr wait for D-dimer or USS)

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)

## Additional Patient Information for ED DVT Referral

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### Patient Details

NHI:

Given name:

Surname:

Address:

DOB:

Sex:

Ethnicity:

Day Ph:

Alternate Ph:

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### Referrer Details

GP Name:

NZMC No:

Address:

Ph:

Fax:

Patient's usual GP:

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### Current Medications:

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### Medication Alerts:

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