## Appendix 2 – Referral Form

# DVT Request Form Community Ultrasound

**Surname:** **First Name:**

**Male/Female** ***please circle***

**D.O.B:** **NHS Number:**

**Address**

**Tel:** **Mobile:**

**Leave Message? Y / N**

**Is the patient able to move onto the examination couch unassisted? Y/N**
**If not please refer them to the hospital for their scan where a hoist or moving aid is available.**

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**ULTRASOUND VENOGRAM OF THE RIGHT / LEFT LEG**

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**Clinical Information & Relevant Medical History:**

**Please complete the boxes below.**

**Well's score** ☐ **(Positive = 2 or more)**

D Dimer ☐

**Please note the request will be returned if both of the above values are negative.**

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**Urgency:** **Urgent**

**Please advise the patient that they will be contacted by our administration team by telephone today to make an urgent appointment.**

**Date:**

**Requesting Dr:** **Surgery Tel:**

**Surgery Address:** **Surgery Fax No:**

**Practice Code :**

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## Exclusions

**Please tick to confirm none of the following exclusions apply:** ☐

**Any patient with suspected cancer. These should be referred through the 2 week referral pathway.**

**Patients with poor mobility who cannot get onto the couch.**

**Chronic (> 2 weeks).**

**Bilateral.**

**Already on Warfarin, Rivaroxaban or other anti-coagulants.**

**Assessed as not clinically fit for treatment.**

**For whom Warfarin and Rivaroxaban are contra-indicated.**

**Where their baseline INR (day 0) > 1.4.**

**Where target INR is not 2.5.**

**Facing imminent surgery.**

**Known alcoholism.**

**Epidural in-situ.**

**That may have problems comprehending or complying with the treatment plan.**

**Pregnant or breast feeding.**

**Has an upper limb DVT.**

**Under 16 years of age.**

**Exhibits chest pain, shortness of breath or haemoptysis.**

**LMWH is contraindicated including renal patients.**

**Patients suspected of having a DVT who fall into any of these categories should be referred directly to Peterborough and Stamford Foundation Trust.**
***If the Patient requires transport, this needs to be organised /arranged by the referring Doctor.***

**Please email this form to capccg.excell@nhs.net.**

| **Location:** | **Provider ID:** |
|---|---|
| **Appointment Date & Time** | |