Postnatal venous thromboprophylaxis risk (VTE) assessment sheet

Assess woman postnatally and if re-admitted postnatally.

All women must be given verbal and written information on VTE.	Information given
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Date	Gestation	Risk category		action	comments	signature/designation
Date	Gostation	High		LMWH*	COMMINICATIO	olginaturo/ deolgination
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		Intermediate		LMWH*		
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		1		ANC		
		Low		Advice only		
Date	Gestation	Risk category		action	comments	signature/designation
		High		LMWH*		
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		Intermediate	П	LMWH*		
				ANC		
		Low		Advice only		
Date	Gestation	Risk category		action	comments	signature/designation
		High		LMWH*		
				ANC		
		Intermediate		LMWH*		
				ANC		
		Low		Advice only		
Date	Gestation	Risk category		action	comments	signature/designation
		High		LMWH*		
			_	ANC		
		Intermediate		LMWH*		
				ANC		
		Low		Advice only		

^{*}Balance risk of bleeding against risk of VTE. Women at high risk of hemorrhage with risk factors including major antepartum hemorrhage, coagulopathy, progressive wound hematoma, suspected intra-abdominal bleeding and postpartum hemorrhage may be managed with foot impulse devices, intermittent pneumatic compression devices or Anti- embolic stocking.

Postnatal prophylactic dose of Low Molecular Weight Heparin (LMWH)

Once daily dosing for postnatal prophylaxis.

Booking weight	Once daily dosing
< 50 kg	2500 units once daily
50 - 90 kg	5000 units once daily
91 - 130kg	7500 units once daily
131-170 kg	10000 units once daily
> 170 kg	Discuss with Consultant Haematologist

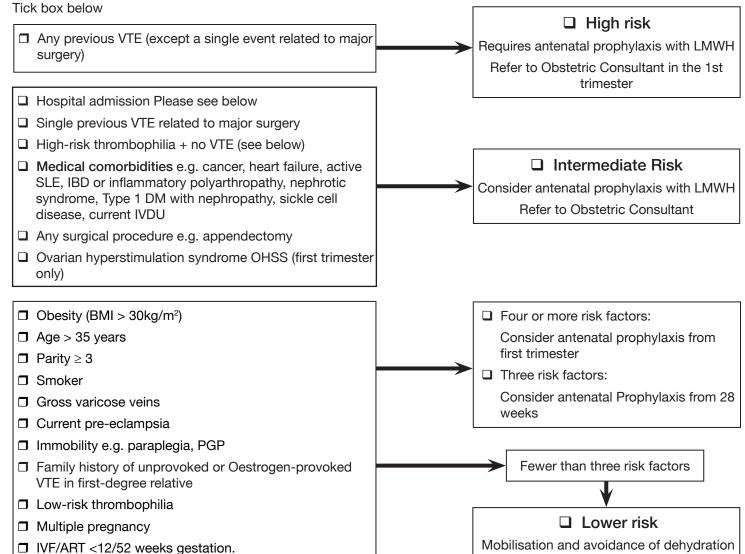
Use a combination of 2500 unit, 5000 unit, 7500 unit and 10000 unit dalteparin pre-filled syringes.

For obstetric use dalteparin is a red (hospital only) drug and ongoing supplies should be prescribed by the hospital clinician.

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Antenatal venous thromboprophylaxis (VTE) risk assessment and management (to be assessed at booking, 36 weeks gestation and repeated at any hospital admission)

Document on risk assessment sheet overleaf



Transient risk factors: Dehydration/hyperemesis, current systemic infection, long distance travel

Bleeding risks / exclusion criteria

Patient related

Active bleeding

Acquired bleeding disorders (e.g. acute liver failure)

Concurrent use of anticoagulants known to increase the risk of bleeding (such as warfarin with INR >2)

Acute stroke

Thrombocytopenia (platelets <75 x 10⁹/L)

Uncontrolled systolic hypertension (200 mmgHg or >120 mmgHg diastolic)

Untreated inherited bleeding disorders (such as haemophilia and von Willebrand's disease)

Severe renal disease (CrCl <30ml/min)

Severe liver disease (prothrombin time above normal range or known varices)

Women considered at increased risk of major haemorrhage (e.g. placenta praevia

Surgical procedure with a high bleeding risk

Lumbar puncture/epidural/spinal anaesthesia within the next 12

Lumbar puncture/epidural/ spinal anaesthesia with in the previous

Thrombophilias

Low risk (+ no previous VTE)

Heterozyqous

Prothrombin gene mutation / Factor V Leiden

Protein C deficiency

Protein S deficiency

High risk (+ no previous VTE)

Homozygous FVL/PGM or compound abnormalities

Anti-thrombin deficiency: Anti-phospholipid syndrome

Anticardiolipin antibodies / Lupus anticoagulant

Hospital admissions:

All women should receive LMWH for the duration of their admission

If prolonged admission for 3 or more days or persistent transient risk factors, then LMWH should be considered for the duration of the pregnancy and up to 6 weeks postpartum.

Antenatal venous thromboprophylaxis risk (VTE) assessment sheet

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				ANC		
		Low	П	Advice only	1	

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Once daily dosing for antenatal prophylaxis.

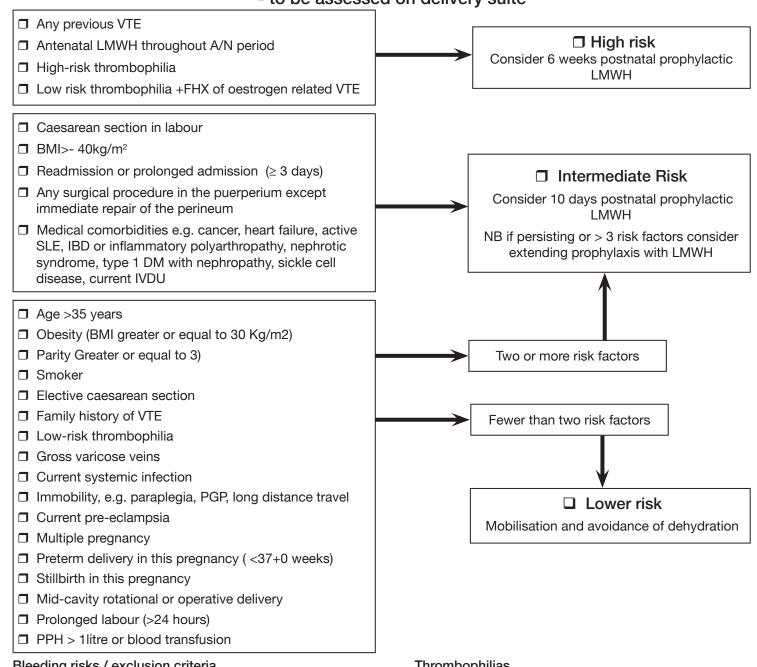
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Version 5.4 Guidance based on RCOG Green-top Guideline No 37a April 2015 and NICE CG 92 January 2010. Approved by DTC December 2010. Revised June 2016. Next review due 2019

Postnatal venous thrombophrophylaxis (VTE) risk assessment and management - to be assessed on delivery suite



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