**Suspected Deep Vein Thrombosis Referral Form**

**email:** [shc-tr.salisbury-rapidreferralcentre@nhs.net](mailto:shc-tr.salisbury-rapidreferralcentre@nhs.net)

**\* PLEASE TICK THIS BOX TO CONFIRM THAT THERE IS CONSENT FROM THE PATIENT TO SHARE THEIR RECORDS AND AMEND THE COMPUTER RECORD ACCORDINGLY**

**Patient Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hospital no. |  | NHS no. |  | | |
| Surname |  | Forenames |  | | |
| Previous surname |  | Title |  | Sex |  |
| Date of birth |  |  |  | | |
| Address  Post Code |  | Home tel. No. |  | | |
| Work tel. No. |  | | |
| Mobile no. |  | | |

**Referral Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring clinician |  | Date of referral |  |
| GP Practice/ Department |  |  | |

**Communication and Accessibility needs:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Interpreter required? | Yes |  | No |  |  | Wheelchair access required? | Yes |  | No |  |
| Language: |  | | | | |  |  | | | |
| Communication & Accessibility Needs: | Hearing: | | | | | Learning Disability: |  | | | |
| Vision: | | | | | Other Disability: |  | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Two-level DVT Wells score** | **score** | | | |
| Active cancer (treatment ongoing, within 6 months, or palliative) | | **1** | |  |
| Paralysis, paresis or recent plaster immobilisation of the lower extremities | | **1** | |  |
| Recently bedridden for 3 days or more or major surgery within 12 weeks requiring general or regional anaesthesia | | **1** | |  |
| Localised tenderness along the distribution of the deep venous system | | **1** | |  |
| Entire leg swollen | | **1** | |  |
| Calf swelling at least 3cm larger than asymptomatic side | | **1** | |  |
| Pitting oedema confined to the symptomatic leg | | **1** | |  |
| Collateral superficial veins (non-varicose) | | **1** | |  |
| Previously documented DVT | | **1** | |  |
| An alternative diagnosis is at least as likely as DVT | | **-2** | |  |
| **DVT likely – 2 points or more** | |  |  | |
| **Please tick as appropriate** | | **YES (✓)** | | |
| Strong family history (2 +1st degree relative) | |  |  | |
| Recent long distance travel | |  |  | |
| Pregnancy | |  |  | |
| **Please refer to the diagram** | |  | | |

|  |
| --- |
| **Side required Right leg  Left leg**  **Presenting clinical symptoms:**  What do you want us to do with the result of a positive scan?   1. For GP review. Please ensure that you have made a follow up appointment to see your patient 2. Follow hospital policy (includes referral to nurse led anticoagulant service +/- MAU review if appropriate.   If you do not tick a box we will default to 2  Please note, equivocal scans will be sent back for review by the referrer  ***Doctor’s signature:***  **It is legal requirement for technologists to have clinical information and authorised signature. Failure to comply will result in delay and/or cancellation of the test**  **Please also use this referral form for severe thrombophlebitis. Use link for treatment options:**  [**https://viewer.microguide.global/guide/1000000295#content,5a9c5bb3-43ff-4ab1-8e0e-63ed2bc421e1**](https://viewer.microguide.global/guide/1000000295#content,5a9c5bb3-43ff-4ab1-8e0e-63ed2bc421e1) |

|  |
| --- |
| **Please attach patients PMH (relevant social), current medication list, or copy of ED record- state if medicines in dossett / blister pack** |

