**Suspected Deep Vein Thrombosis Referral Form**

**email:** 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 |  |  |  |
| AddressPost 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 2Please 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** |

