

Venous Thrombo-Embolism (VTE) Risk Assessment Form

Directions: 1. To be completed by Physician
2. Indicate choice when options are available by placing a check in the box

Attending Physician: _____ Diagnosis: _____

Observation Status Admission for Inpatient Care Admit or transfer to: _____ Unit

ALLERGIES: NKA **ALLERGIC to:** _____

<input type="checkbox"/> Immobility	
<p>Medical Diagnosis</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Heart Failure</p> <p><input type="checkbox"/> Acute MI or MI History (Not r/o MI)</p> <p><input type="checkbox"/> COPD</p> <p><input type="checkbox"/> Cancer & Chemotherapy</p> <p><input type="checkbox"/> Nephrotic Syndrome</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Inflammatory Bowel Disease</p> <p><input type="checkbox"/> Thrombotic abnormalities</p> <p><input type="checkbox"/> Systemic Lupus</p> <p><input type="checkbox"/> Infections/sepsis</p> <p><input type="checkbox"/> Acute rheumatic disorders</p> <p><input type="checkbox"/> Isolated lower extremity fractures</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p> <p>Other</p> <p><input type="checkbox"/> _____</p>	<p>Major Surgery/Trauma:</p> <p><input type="checkbox"/> General surgery i.e., Elective GI, Chest</p> <p><input type="checkbox"/> Gynecologic</p> <p style="padding-left: 20px;"><input type="checkbox"/> Urologic</p> <p><input type="checkbox"/> Neurosurgery</p> <p><input type="checkbox"/> Acute spinal injury</p> <p><input type="checkbox"/> Burns</p> <p><input type="checkbox"/> Trauma</p> <p>Orthopedic Surgery</p> <p><input type="checkbox"/> Hip/knee</p> <p><input type="checkbox"/> Hip fracture surgery</p> <p><input type="checkbox"/> Spinal surgery</p> <p>Additional Risk Factors</p> <p><input type="checkbox"/> Increasing age (over 40)</p> <p><input type="checkbox"/> Obesity</p> <p><input type="checkbox"/> History of DVT or PE</p> <p><input type="checkbox"/> Pregnancy high risk (presence of one or more)</p> <p style="padding-left: 20px;">- History of DVT or superficial thrombophlebitis</p> <p style="padding-left: 20px;">- Documented thrombophilia</p> <p style="padding-left: 20px;">- Prolonged surgery (greater than 2hrs)</p> <p style="padding-left: 20px;">- Methylene tetrahydrofolate Reductase (MTHFR) deficiency</p> <p><input type="checkbox"/> Estrogen use (Oral Contraceptive/HRT)</p> <p><input type="checkbox"/> Smoker</p>
<p>(Must Check One)</p> <p><input type="checkbox"/> VTE Prophylaxis <u>Not</u> Required: No Risk Factors</p> <p><input type="checkbox"/> VTE Prophylaxis <u>Not</u> Required: Therapeutically Anti-coagulated</p> <p><input type="checkbox"/> VTE Prophylaxis <u>Required</u>: VTE Prophylaxis Order Set Implemented</p> <p><input type="checkbox"/> VTE Prophylaxis <u>Required</u>: Other Order Set Used for VTE Prophylaxis</p> <p>Physician Signature: _____ Date: _____ Time: _____</p> <p><input type="checkbox"/> Verbal Read Back</p>	

Patient Identification