



= YES     = NO

(PLACE PATIENT LABEL HERE)

SURNAME: \_\_\_\_\_ NHI: \_\_\_\_\_

FIRST NAMES: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      SEX: \_\_\_\_\_

## DEEP VEIN THROMBOSIS

Date:    /    / 20      Time:      Clinician:       NP     CNS     HS     Reg     SMO

### HISTORY AND PRESENTING COMPLAINT

Suspected DVT:       Right       Left      *See best care bundle investigation and treatment guide*

#### DVT risk factors:

- Bedridden recently >3 days or major surgery within 4 weeks
- Entire leg swollen
- Paralysis, paresis, or recent plaster immobilisation of lower extremity

#### Systems review

- Gen:     Fever/ chills
- CVS:     Palpitations  
 Syncope
- Resp:     Chest pain  
 Shortness of Breath  
 Haemoptysis  
 Cough

### RELEVANT PREVIOUS MEDICAL HISTORY

Nil relevant

- Ca Hx:     Active Cancer
- DVT:     Previous documented DVT:
- C.I.:     CVA haemorrhagic <3/12  
 PUD / GIB < 3/12  
 Renal impairment  
 Liver impairment

### RELEVANT MEDICATIONS / ALLERGIES

Nil regular medicines

- Aspirin     Warfarin     Dabigatran     Other anticoagulants *e.g. Rivaroxaban*
- Oral contraceptive

Nil known allergies      **ALLERGIES:**



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**FUNCTIONAL AND SOCIAL HX**

Living situation: <input type="checkbox"/> alone	Mobility: <input type="checkbox"/> independent	Activities of daily living: <input type="checkbox"/> independent
<input type="checkbox"/> with family	<input type="checkbox"/> walking stick	<input type="checkbox"/> needs some help e.g. cleaning
<input type="checkbox"/> rest home	<input type="checkbox"/> walking frame	<input type="checkbox"/> significant help e.g. dressing
<input type="checkbox"/> private hospital	<input type="checkbox"/> wheelchair	<input type="checkbox"/> needs help eating
<input type="checkbox"/> other: _____	<input type="checkbox"/> immobile	<input type="checkbox"/> completely dependent
Occupation _____		
Supports _____		
Transport _____		

**VITAL SIGNS**

Within normal limits

BP \_\_\_\_\_ mmHg

Pulse \_\_\_\_\_ bpm

Temp \_\_\_\_\_ °C

Resp Rate \_\_\_\_\_ min

SPO2 \_\_\_\_\_ %

Air     NP     Hudson: \_\_\_\_\_ l/min

Pain score \_\_\_\_\_ /10

Glucose \_\_\_\_\_ mmol/L

General  NOT distressed

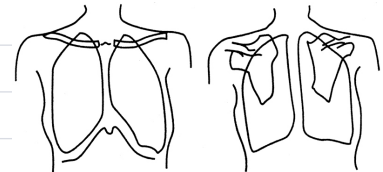
Pain  None     Mild     Moderate     Severe

**EXAMINATION**

CVS  Warm and well perfused

Cap refill  Normal

Pulses  Normal



**Respiratory**

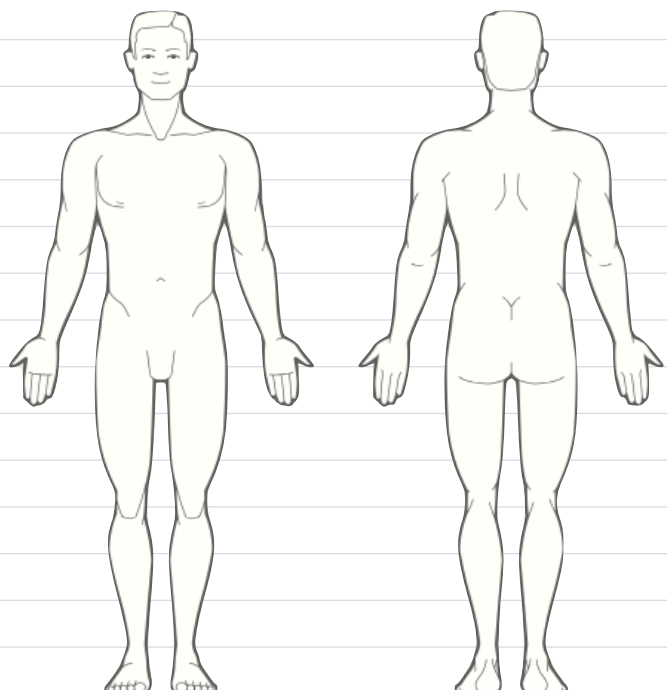
Breathing work  Normal

Breath sounds  Vesicular

Added sounds  No     Yes:

**ABDOMEN**

Palpation  Soft



**LIMB DESCRIPTION**

*Right*

*Left*

Tender

Swollen

Erythematous

Calf size:

**NEUROVASCULAR STATUS**  Normal     Compromised





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**CLINICAL IMPRESSION / DIAGNOSIS / PLAN**

Blank lined area for clinical impression, diagnosis, and plan.

**MANAGEMENT/ PLAN** See page 4 best care bundle for treatment guide

Large blank lined area for management and plan.

Discharge checklist  Check list on page 4 best care bundle completed and documented

Patient information sheet provided *In Bundle pack or EM CeDSS*

Thrombosis referral completed

Referral note  Inpatient referral: Discussed with Dr: \_\_\_\_\_ Time: \_\_\_\_\_

Gen Med

Clinician Name: \_\_\_\_\_ Designation: \_\_\_\_\_ Sign: \_\_\_\_\_ Contact details: \_\_\_\_\_

For junior staff:  Discussed with  Reviewed by SMO Dr : \_\_\_\_\_ Sign: \_\_\_\_\_

EMERGENCY MEDICINE NOTES