

**THROMBOSIS OUTPATIENT
TREATMENT PROGRAM - VGH CLINIC**

(items with check boxes must be selected to be ordered)

PCIS Label

ACUTE VENOUS THROMBOEMBOLISM INCLUSION/EXCLUSION CRITERIA

Nurses
Initials

INCLUSION CRITERIA

ALL MUST BE "YES" FOR ENROLLMENT

YES	NO	
		18 years of age or older
		Proven acute venous thrombosis: <input type="checkbox"/> proximal leg DVT (common femoral, superficial femoral, popliteal vein) <input type="checkbox"/> distal leg DVT (posterior tibial, anterior tibial, peroneal vein) <input type="checkbox"/> stable PE (no acute syncopal episode, vital signs must be stable with walking, O ₂ sat greater than 92% on room air, no prior cardiopulmonary disease, pain easily controlled) <input type="checkbox"/> upper extremity DVT
		Outpatient follow-up feasible at VGH Clinic

EXCLUSION CRITERIA

ALL MUST BE "NO" FOR ENROLLMENT

YES	NO	
		Clinically unstable for outpatient therapy
		Active bleeding, familial (e.g. hemophilia) or acquired (e.g. DIC) bleeding disorder
		Recent GI / GU bleed (one month), hemorrhagic stroke (three months), surgery or trauma (one month). Consider contacting Hematologist on call for discussion
		Severe uncontrolled hypertension (systolic BP greater than or equal to 180 mmHg or diastolic BP greater than or equal to 110 mmHg)
		Platelet count less than 50 X 10 ⁹ /L
		History of heparin-induced thrombocytopenia (HIT) or allergy to heparin or warfarin
		Renal failure requiring dialysis
		Liver failure with coagulopathy
		Evidence of massive iliofemoral thrombosis
		Require hospitalization for other reasons (e.g. pain control, dementia and poor social support)

ADDITIONAL COMMENTS

Date _____ Time _____ Printed Name _____ Signature _____ College ID _____

**THROMBOSIS OUTPATIENT
TREATMENT PROGRAM - VGH CLINIC**

(items with check boxes must be selected to be ordered)

PCIS Label

Complete ACUTE VTE INCLUSION/EXCLUSION CRITERIA form on page 1 prior to enrollment.
 No intramuscular injections.
 If possible, avoid acetylsalicylic acid (ASA), non-steroidal anti-inflammatory drugs (NSAIDS), ticlopidine, clopidogrel, dipyridamole, sulfipyrazone.
 Print PharmaNet profile.

INVESTIGATIONS

Baseline Labs: CBC, PTT, INR, Iytes, Urea, SCr.

MEDICATIONS

Day of diagnosis

For **ALL** patients, give dalteparin according to following weight-based schedule. Patient Weight: _____kg

Patient Weight (kg)	Dalteparin Dose (volume based on 25,000 units/mL concentration)
<input type="checkbox"/> 45 to 56	10,000 units (0.4 mL) Subcutaneous
<input type="checkbox"/> 57 to 68	12,500 units (0.5 mL) Subcutaneous
<input type="checkbox"/> 69 to 82	15,000 units (0.6 mL) Subcutaneous
<input type="checkbox"/> 83 to 90	18,000 units (0.72 mL) Subcutaneous
<input type="checkbox"/> 91 to 100	20,000 units (0.8 mL) Subcutaneous
<input type="checkbox"/> 101 to 115	22,500 units (0.9 mL) Subcutaneous
<input type="checkbox"/> 116 to 135	25,000 units (1 mL) Subcutaneous
<input type="checkbox"/> 136 to 145	28,000 units (1.12 mL) Subcutaneous
<input type="checkbox"/> greater than 145	Consult Hematologist on call for dosing

Time of first dose _____ hours on _____ (mm/dd/yy).

Do not give oral anticoagulation. This will be assessed in the Thrombosis Clinic

Nurses
Initials

Date Time Printed Name Signature College ID



**THROMBOSIS OUTPATIENT
TREATMENT PROGRAM - VGH CLINIC**

(items with check boxes must be selected to be ordered)

PCIS Label

BEFORE DISCHARGE THIS FORM MUST BE COMPLETED and ALL SECTIONS INITIALED

Nurses
Initials

UNIT CLERK

- Fax current ED record, PharmaNet profile, MedRec Form, laboratory reports, radiology report or notes, and these pre-printed orders to the VGH Thrombosis Clinic (604 875 5071).

Faxed Date _____ Time _____ NUC Initials _____

INFORMATION TO PATIENT

Nurse to confirm the following: RN Initials _____

- Patient has been given the VGH Thrombosis Outpatient Treatment Program Information Sheet (page 4/5 of this package) and is aware that they must go there tomorrow to continue to receive treatment.
- Patient is aware to call VGH Thrombosis Clinic by 0900 the following weekday if the patient has not received a call from them

REFERRAL TO THROMBOSIS CLINIC

EMERGENCY PHYSICIAN:

- Please ensure ED NUC faxes information to Thrombosis Clinic as above before patient discharge and all above sections initialed.
- If following day is Monday-Friday, advise patient that they will be called before 0900 tomorrow with appointment. (Thrombosis Clinic, Centennial Pavilion 6th floor)
- If following day is Saturday, Sunday or Statutory Holiday, **Emergency Physician must page Staff Hematologist on call**. They will set up appointment directly with patient. (BMT Daycare, Centennial Pavilion 6th floor; if patient has fever or other infectious symptoms, should be accompanied by someone who is not ill)

Hematologist name: _____

Complete table with important names and verified phone numbers:

	Name	Phone Number
Emergency physician		MSP #
Family physician		
Patient		
Alternate contact		

Date Time Printed Name Signature College ID