

**REMINDER: ALL MEDICATION ORDERS REQUIRE DOSE, ROUTE, FREQUENCY AND INDICATION  
DO NOT USE ABBREVIATIONS**

<b>DOCTORS ORDERS</b>	<b>CHECK OFF/ INITIALS</b>
<b>DVT / PE Prophylaxis Protocol: Hospitalists Pilot Protocol</b>	
<p style="text-align: center;">All patients should be assessed for DVT / PE prophylaxis. Assessment of risk factors can be initiated by a nurse or pharmacist as well as the physician</p>	
<p>1. <input type="checkbox"/> If patient is currently receiving Low Molecular Weight Heparin, Unfractionated Heparin or Warfarin (Coumadin®) Check box, stop assessment and sign at the bottom.</p>	
<p style="text-align: center;"><b>Risk Factors: (Equally weighted; each inclusion equals one on the risk score)</b></p>	
<p>2. <input type="checkbox"/> Age more than 40 years old  <input type="checkbox"/> ICU admission  <input type="checkbox"/> Prior history DVT or PE  <input type="checkbox"/> Ischemic stroke  <input type="checkbox"/> Inflammatory disorder  <input type="checkbox"/> Central venous line / catheter  <input type="checkbox"/> Major abdominal / pelvic / lower limb surgery  <input type="checkbox"/> Hip, leg or pelvic fracture  <input type="checkbox"/> Lower limb arthroplasty  <input type="checkbox"/> Hypercoagulative state or collagen disorder</p>	<p><input type="checkbox"/> Immobility more than 24 hours  <input type="checkbox"/> Obesity more than 20% over IBW  <input type="checkbox"/> Heart failure with swollen legs  <input type="checkbox"/> COPD or respiratory failure  <input type="checkbox"/> Pneumonia  <input type="checkbox"/> Malignancy  <input type="checkbox"/> Multiple trauma  <input type="checkbox"/> Sepsis  <input type="checkbox"/> Varicose veins  <input type="checkbox"/> Pregnancy / Post partum less than one month</p>
<p><b>Calculated Risk Score = _____</b></p>	
<p><b>Exclusion criteria:</b></p>	
<p>3. <input type="checkbox"/> Active bleed  <input type="checkbox"/> History of Heparin Induced Thrombocytopenia or past sensitivity to Heparin  <input type="checkbox"/> Head trauma, Head or Eye surgery less than 3 months  <input type="checkbox"/> Abnormal baseline APPT  <input type="checkbox"/> Patient under 18 years old</p>	<p><input type="checkbox"/> Coagulopathy  <input type="checkbox"/> Uncontrolled hypertension  <input type="checkbox"/> Spinal tap or epidural within 12 hours  <input type="checkbox"/> Platelets less than 50,000  <input type="checkbox"/> Recent intracranial bleed  <input type="checkbox"/> Other: _____</p>
<p><b>4. Treatment:</b> (Must be filled out by physician or designee) Based on total risk factors select risk category, then indicate choice(s) for prophylaxis</p>	
<p><input type="checkbox"/> <b>Risk score 3 Consider mechanical prophylaxis</b></p>	
<p><input type="checkbox"/> Sequential compression devices <input type="checkbox"/> Knee <input type="checkbox"/> Foot pump  <input type="checkbox"/> Graduated compression stockings (If ambulatory)</p>	
<p><input type="checkbox"/> <b>Risk score 4-5</b> Adding pharmacologic prophylaxis should be considered</p>	
<p><input type="checkbox"/> Sequential compression devices <input type="checkbox"/> Knee <input type="checkbox"/> Foot pump  <input type="checkbox"/> Graduated compression stockings (If ambulatory)  <input type="checkbox"/> Enoxaparin (Lovenox®) 40 mg subcutaneous every 24 hours (30 mg subcutaneous every 24 hours if creatinine clearance less than 30 ml/minute).  <input type="checkbox"/> Unfractionated heparin 5000 units subcutaneous every 8 hours.</p>	
<p><input type="checkbox"/> <b>Risk score 6 or above</b> Pharmacologic prophylaxis recommended with added devices</p>	
<p><input type="checkbox"/> Sequential compression devices <input type="checkbox"/> Knee <input type="checkbox"/> Foot pump  <input type="checkbox"/> Graduated compression stockings (If ambulatory)  <input type="checkbox"/> Enoxaparin (Lovenox®) 40 mg subcutaneous every 24 hours (30 mg subcutaneous every 24 hours if creatinine clearance less than 30 ml/minute).  <input type="checkbox"/> Unfractionated heparin 5000 units subcutaneous every 8 hours.</p>	
<p><b>Implement Anticoagulation: Laboratory Support Orders</b></p>	
<b>Physician/Date/Time:</b>	<b>Nurse/Date/Time:</b>
	<b>Secretary/Date/Time:</b>

**Full page of orders requires only one physician, one nurse and one clerical signature**



Original to Patient's Chart

Fax to Pharmacy