IF YOU RECEIVED THIS FAX IN ERROR, CALL 604-806-8886 IMMEDIATELY

Providence HEALTH CARE

PRESCRIBER'S ORDERS

NO DRUG WILL BE DISPENSED OR ADMINISTERED WITHOUT A COMPLETED

CAUTION SHEET

ALLERGY/INTOLERANCE STATUS FORM (PHC-PH047)

DATE AND TIME

INTRA-OPERATIVE AND PACU
VTE RISK ASSESSMENT AND MECHANICAL PROPHYLAXIS ORDERS

(items with check boxes must be selected to be ordered) **(Page 1 of1)**

VTE Risk Assessment: See back for details of patient risk groups.

- ☐ Low risk: Early ambulation. No mechanical prophylaxis.
- ☐ Moderate or High risk: Order mechanical prophylaxis.

Mechanical Prophylaxis: See back for mechanical prophylaxis recommendations

- ☐ Sequential compression device (SCD)
- ☐ Mechanical prophylaxis contraindicated (see back for list of contraindications).

Please specify contraindication: _____

Duration of Mechanical Prophylaxis: Apply to lower limb(s) continuously until:

- ☐ anticoagulant prophylaxis starts (within 12 to 24 hours of surgery end time) for same day admit and inpatients
- ☐ patient is discharged from PACU for surgical daycare patients

Interrupt ONLY for skin care, assessments, toileting and ambulation.

If SCD therapy has been interrupted for longer than 60 minutes please contact most responsible physician for further direction in regards to re-initiation of SCD therapy.

Printed Name	Signature	College ID	Pager

ALL NEW ORDERS MUST BE FLAGGED

PRE- AND INTRA- OPERATIVE VTE RISK ASSESSMENT AND RECOMMENDED INTRA-OPERATIVE MECHANICAL PROPHYLAXIS RECOMMENDATION

Low Risk Group	Moderate or High Risk Group
• Day surgery[1] patients without any VTE risk factors (see below) • No reduction in mobility compared to usual state • Surgical procedure with a total anesthetic and surgical time of less than 60 minutes with no risk factors for VTE (see below)	• Any medical or surgical patient having had or are expected to have significantly reduced mobility for 3 days or more[2-9] • Medical patients with ongoing reduced mobility (compared to their usual state) AND have one or more risk factors for VTE (see below) [2,7-9] • Surgical procedure with a total anesthetic and surgical time of 60 minutes or longer[3-6] • Acute surgical admission with an inflammatory or intra-abdominal condition[3-6] • Surgical patients with one or more risk factors for VTE (see below) [3-5]
No mechanical prophylaxis required	Mechanical prophylaxis required

RISK FACTORS FOR VTE

• Age 60 years and over • Active cancer and cancer treatment • Previous VTE • Critical Care admission • Obesity (BMI above 30 kg/m^2) • Known thrombophilia • First degree relative with VTE • Varicose veins with phlebitis • Estrogen-containing oral contraception • Hormone replacement therapy • Pregnancy and the postpartum period	One or more significant medical conditions: • Sepsis or severe acute infection • Heart disease (e.g CHF) • Respiratory pathology (e.g. COPD) • Inflammatory condition (e.g.inflammatory bowel disease) • Rheumatological disease • Nephrotic syndrome • Antiphospholipid syndrome

CONTRAINDICATIONS FOR MECHANICAL PROPHYLAXIS

- Acute stroke with immobility (unable to walk independently to the toilet)
- Peripheral vascular disease with absent pedal pulses
- Severe peripheral neuropathy
- Skin breakdown, ulcers, gangrene, cellulitis, or dermatitis
- Skin grafting within last 3 months
- Allergy to stocking or compression cuff materials
- Unable to size or apply properly due to deformity, recent surgery or trauma

FOOTNOTES AND PRECAUTIONS

1. Day surgery includes patients admitted and discharged within 24 hours for an elective surgical or invasive procedure.
2. In medical patients receiving anticoagulant prophylaxis, the NNT to prevent symptomatic DVT is 212 and non-fatal PE is 300; the NNH for major bleed is 430. There is no evidence for mechanical thromboprophylaxis in medical patients.
3. In surgical patients receiving anticoagulant prophylaxis, the NNT to prevent symptomatic DVT is 20 to 106 and non-fatal PE is 110 to 150; the NNH for major bleed is 70 to 100. There is weak evidence for using mechanical thromboprophylaxis alone and weaker evidence for combining anticoagulant and mechanical prophylaxis to improve efficacy.
4. First post-op dose of LMWH should be given after hemostasis is achieved and as soon as it is safe to do so (usually 12 to 24 hr after surgery). This should take into account the risks of bleeding, thrombosis and timing of subsequent surgery if needed.
5. Prophylaxis for up to 30 days after surgery is recommended in those having hip replacement, hip fracture surgery, abdominal or pelvic surgery for cancer, and those with multiple risk factors.
6. Heparin 5,000 units subcut BID should be used if patient is awaiting urgent surgery and is a candidate for neuroaxial blockade. Refer to Peri-operative Pain Service or Anesthesia regarding timing of epidural catheter insertion and removal.
7. Dalteparin and heparin should not be given in patients with heparin induced thrombocytopenia. Consider consulting Hematology regarding the use of alternative agents (e.g. fondaparinux or argatroban).
8. If eGFR is 10 to 30 mL/min and duration of prophylaxis exceeds 10 days, can consider using heparin 5,000 units subcut BID. If eGFR less than 10 mL/min or dialysis dependent, use heparin 5,000 units BID.
9. If patient's weight is over 100 kg, consider increasing dose of dalteparin to 5,000 units BID or heparin 5,000 units TID.

Weight range	dalteparin (if eGFR 10 mL/min or above)	heparin (if eGFR less than 10 mL/min)
40 kg or less	2,500 units subcutaneous once daily	2,500 units subcutaneous Q12H
41 kg to 100 kg	5,000 units subcutaneous once daily	5,000 units subcutaneous Q12H
Over 100 kg	5,000 units subcutaneous Q12H	5,000 units subcutaneous Q8H