A THERAPEUTICALLY EQUIVALENT PRODUCT MAY BE DISPENSED AND ADMINISTERED UNLESS CHECKED IN THE LEFT COLUMN.

✓	VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS	ROOM NO.

ALLERGIES (list reactions): HT _____ (Cm) WT _____ (Kg)

A ☑ indicates a selected order. If a defaulted order is not appropriate or there is a change to an order, draw a line through the order and initial.

NURSING: Select one below and fill in blank to the right. **Total VTE Risk Assessment Score:** ☐

☐ **Initial VTE risk assessment**

☐ **VTE risk assessment due to change in patient status. Indicate which change in status by circling.**
(Code, Transfer to higher level of care, Surgery, Bed confinement > 72 Hrs, Immobilized > 72 Hrs, New cancer diagnosis, New central line placement)

PHYSICIAN:

☐ See pre-printed or handwritten order for VTE prophylaxis

☐ Patient currently on anticoagulation therapy

☐ Anticoagulation contraindicated; Reason: _____

The nursing VTE Risk Assessment can be found behind the Admission Assessment tab.

☐ **MODERATE RISK (VTE Risk Assessment Score 2-4)**

☑ Sequential compression device (SCD)

☐ Enoxaparin (Lovenox) 40 mg SubQ daily. Start Date: _____
Pharmacy to decrease dose to 30 mg SubQ daily for creatinine clearance < 30 mL/min,

or ☐ Heparin 5000 units SubQ Q 8 Hrs. Start Date: _____

or ☐ other _____
Start Date: _____

☐ **HIGH RISK** (VTE Risk Assessment Score ≥ 5)

☑ Sequential compression device (SCD)

AND one of the following:

☐ Enoxaparin (Lovenox) 40 mg SubQ daily. Start Date: _____
Pharmacy to decrease dose to 30 mg SubQ daily for creatinine clearance < 30 mL/min,

or ☐ Heparin 5000 units SubQ Q 8 Hrs. Start Date: _____

or ☐ other _____
Start Date: _____

12-hour Chart Check_____ **RN DATE:** _____ / _____ / _____ **TIME:**_____

T.O. _____ **Taken by:** _____ ____/____/____, **TIME:**_____

TRANSCRIBED BY: _____ ____/____/____, **TIME:** _____ **NOTED BY:**_____ ____/____/____, **TIME:**_____

PHYSICIAN SIGNATURE:_____ **DATE:** _____ **TIME:** _____

PRINTED NAME/ID#:

(COUNTER-SIGN ALL T.O. ORDERS WITHIN 48 HOURS, AND INCLUDE THE DATE/TIME AUTHENTICATED)

St. Joseph Hospital
ST. JOSEPH HEALTH SYSTEM

VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS

PATIENT ID

EXCLUSION CRITERIA FOR ANTICOAGULATION	
ABSOLUTE EXCLUSION CRITERIA (Do **Not** Use Anticoagulation)	**RELATIVE EXCLUSION CRITERIA** (Use Anticoagulation with Caution)
• Heparin/LMWH/warfarin use in heparin-induced thrombocytopenia • Indwelling epidural/spinal catheter • Spinal tap or epidural catheter within 24 hours • Active hemorrhage • Severe trauma to head, spinal cord, or extremities with hemorrhage within last 4 weeks • Known hypersensitivity to heparin, LMWH, or pork products • Warfarin use in pregnancy	• Recent intraocular, intracranial, or spinal surgery • Uncontrolled hypertension • History of cerebral hemorrhage • GI/GU bleed or hemorrhagic stroke within last 6 months • Thrombocytopenia • Coagulopathy • Active intracranial lesions/neoplasm • Diabetic retinopathy