

# HOW TO FILL VTE IN GOOGLE CHROME

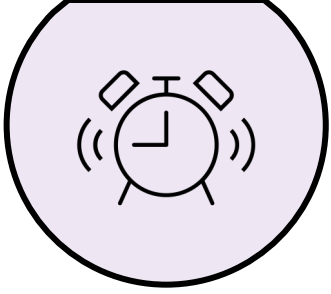


<https://docs.google.com/forms/d/e/1FAIpQLSfLevpwnY35AcsqjM8dbu0ncAJxmOWpCBO9AexIOEOZ-wEKeQ/viewform?c=0&w=1&fbzx=5055179076345049000>



## VTE OBSTETRIC AUDIT

This form is used for obstetric patient (not for Gynecological cases). Please choose your patient according to sample size for your hospital (in VTE audit document).



- ✓ You Should open the link with google Chrome.
- ✓ Any data with a red star **\***, it's Mandatory to fill it up.
- ✓ The VTE should be completed before discharge.

Patient File Number \*

Your answer

**Write File Number without first Zeroes if file Number 000324 only write 324**

Hospital name \*

Please choose your hospital from the list below

Choose

**Choose the Hospital (MCHD)**

Date of admission \*

DD MM YYYY

/ /

**Pick up the Date of admission from Calendar**

Time of admission \*

Time

:

**Write the admission time and choose( AM, PM) and if you write the 24 hrs. time it will calculate to 12 hrs. time example (13)→1PM, 00:00 →12:00PM But if you write 12:00 be sure to choose (AM or PM).**

Where is the patient location \*

- ☐ ICU
- ☐ Ward
- ☐ Delivery room

Age group \*

Choose ▼

BMI \*

Choose ▼

Multiple pregnancy \*

- ☐ Yes
- ☐ No

Is the patient

Choose  
from  
the list

Singleton prg.  
Choose **(No)** if  
not singleton  
choose **yes**

Parity \*

- ☐ 0
- ☐ 1 to 2
- ☐ 3 or more

Smoking \*

- ☐ Yes
- ☐ No

History of previous VTE or VTE in first degree family \*

- ☐ Yes
- ☐ No
- ☐ Unknown

Next

Clear form

Never submit passwords through Google Forms.

This content is neither created nor endorsed by Google. [Report Abuse](#) - [Terms of Service](#) - [Privacy Policy](#)

Google Forms

### Category

What is patient VTE category \*

- ☐ Antenatal
- ☐ Postnatal

**Where is the  
Patient NOW  
in (ANW OR  
Postnatal)**

Mobility restriction \*

- ☐ Yes
- ☐ No

**Choose from the list**

Back

Next

Clear form

If you choose the Antenatal ward this page will come up, then you must pick up the Antenatal diagnosis if not applicable you can choose other then write the diagnosis.

This diagnosis is for the Postnatal if you choose Postnatal.

Diagnosis

Please choose more than one if applicable

Diagnosis Antenatal \*

☐ Pre-eclampsia/eclampsia

☐ OHSS (first trimester only)

☐ Medical comorbidities e.g. cancer, heart failure, active SLE, IBD or inflammatory polyarthropathy; nephrotic syndrome, type I DM with nephropathy, sickle cell disease, current IVDU

☐ Hyperemesis

☐ Dehydration

☐ Low-risk thrombophilia

☐ High risk thrombophilia and NO DVT

☐ IVF/ART

☐ Gross varicose

☐ Current systemic infection

☐ Others

Back

Next

Clear form

Diagnosis postnatal \*

☐ Caesarean section in labour

☐ Caesarean section elective

☐ Pre-eclampsia/eclampsia

☐ SVD

☐ Preterm delivery

☐ Still birth

☐ surgical procedure in the puerperium except immediate repair of the perineum

☐ Medical comorbidities e.g. cancer, heart failure, active SLE, IBD or inflammatory polyarthropathy; nephrotic syndrome, type I DM with nephropathy, sickle cell disease, current IVDU

☐ PPH (> 1 litre or transfusion)

☐ Prolonged labour (> 24 hours)

☐ Others

Back

Next

Clear form

Specify

Other diagnosis

Your answer

Back

Next

Clear form





Risk assessment

Is VTE risk assessment documented somewhere? \*

☐ No

☐ Yes

Date of risk assessment completed \*

DD MM YYYY

/ /

Time of risk assessment completed \*

Time

:

Back

Next

This sheet for the Risk Assessment form If it's done in the patient file or not.

Choose the date and time of risk assessment completed. There is different assessment forms (Adult assessment, Antenatal Assessment and Postnatal Assessment)

Risk documentation

Where is documented? \*

☐ Risk Assessment Form

☐ Pre-Admission Form

☐ Care Plan

☐ Progress Note

Risk category \*

☐ Low risk

☐ intermediate

☐ High-risk

Back

Next

Clear form

Where is the risk Assessment documented?

Type of risk





## Contraindication

Are there any contraindications to VTE prophylaxis? \*

- ☐ Yes
- ☐ No
- ☐ Not documented

Back

Next

If No or Not Documented, press Next.

If you choose **YES**, this sheet will come up, and it's mandatory.

If the patient has any contraindication about prophylaxis.

## Reason

If there is contraindications please specify \*

- ☐ Active bleeding
- ☐ Hypersensitivity to low molecular weight heparin, unfractionated heparin, (including heparin- induced thrombocytopenia)
- ☐ Patient on therapeutic dose of Heparin/Enoxaparin or therapeutic INR
- ☐ Uncontrolled HTN (SBP> 185 and /or DBP> 100 mmHg)
- ☐ Epidural anesthesia (within last 24 hrs. or planned within next 24 hrs.)
- ☐ Recent intraocular surgery or intracranial surgery
- ☐ Clinically significant thrombocytopenia (Platelet count less than 100)
- ☒ Other: \_\_\_\_\_

Back

Next

Clear form





**Choose if the physician-ordered VTE prophylaxis is either pharmacological, Mechanical, or both)**

### Prophylaxis

Is VTE prophylaxis ordered? ( Pharmacological and/or Mechanical) \*

- ☐ Pharmacological
- ☐ Mechanical
- ☐ Both
- ☐ Not ordered

**If you choose both, the options will come as (Mechanical and Pharmacological)**

Back

Next

Clear form

### Device

Mechanical \*

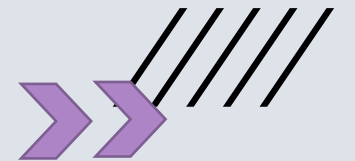
- ☐ Graduated Compression Stockings
- ☐ Pneumatic Compression Devices
- ☐ Foot Pumps

Back

Next

Clear form

**If you choose Mechanically, these are the options on the list**



If you choose  
Pharmacological,  
these are the list of  
Medications.

### Medication type

What is pharmacological prophylaxis? \*

- ☐ LMWH
- ☐ Heparin
- ☐ Warfarin

The common prophylaxis  
used in MCHD is LMWH

Back

Next

Clear form

### Time

VTE prophylaxis starting date \*

DD MM YYYY

/ /

VTE prophylaxis discontinue date

DD MM YYYY

/ /

is the VTE prophylaxis discharge plan documented \*

- ☐ Yes
- ☐ No

Choose from  
the list

Back

Next

Clear form

Choose from  
the calander  
the starting  
date and  
ending date of  
prophylaxis.



### Discharge plan

What is the VTE discharge prophylaxis plan and duration \*

- ☐ Antenatal prophylaxis with LMWH
- ☐ Postnatal 10 days
- ☐ Postnatal 6 week
- ☐ Postnatal 5 to 7 days
- ☐ Postnatal till back to normal physical activity
- ☐ Ambulation and good hydration
- ☐ If others specify next question

Others

Your answer

Back

Next

Clear form

**Discharge plan  
either for  
Antenatal or  
Postnatal**



### Deviation from guidelines

PLEASE ANSWER THIS QUESTION ONLY IF RECOMMENDED PROPHYLAXIS NOT PRESCRIBED

Reason recommended thromboprophylaxis is not used?

- ☐ No Thromboprophylaxis
- ☐ No mechanical device available
- ☐ Mechanical alone without bleeding contraindication.
- ☐ Delay starting(> 24 hours after surgery or > 24 hours after admit
- ☐ Insufficient duration
- ☐ Wrong Drug
- ☐ wrong Dose
- ☐ Patient on therapeutic anticagoulant

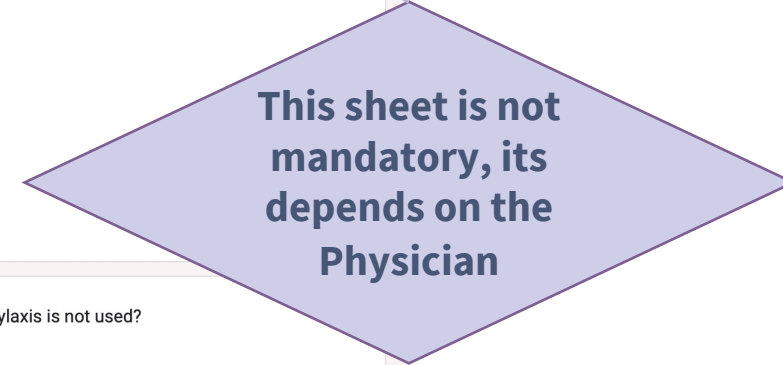
If other please specify

Your answer

Back

Next

Clear form





## Treating physician

Treating physician \*

Your answer

**Name of Consultants**

Did the risk assessment signed by treating physician \*

☐ Yes

☐ No

**Choose**

Audit entered by \*

Your answer

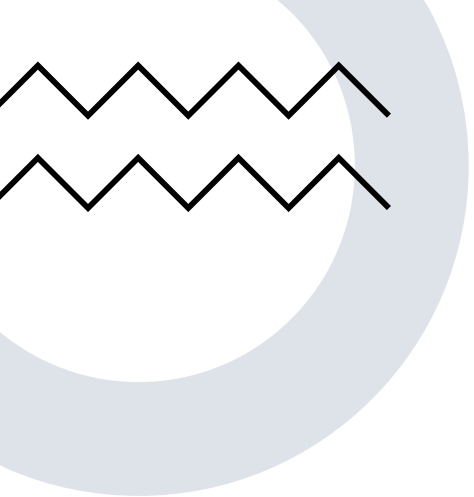
**This Form Filled by  
Your Name**

**Back**

**Submit**

**Clear form**





Done By  
Fatimah Al-Eid  
Clinical improvement services

Head of Clinical improvement services  
Dr.Bassam Al-Hejili

