Venous Thromboembolism during Pregnancy, Labour and the Post-partum Period Risk Assessment Clinical Guideline

V2.2

December 2019
1. **Aim/Purpose of this Guideline**

1.1. This gives guidance to midwives and obstetricians in the timing of risk assessments for venous thromboembolism (VTE) during pregnancy, labour and post-natal period and the referral pathway for those women identified as being at risk.

1.2. This gives guidance to obstetricians on the planning and prescribing of thromboprophylaxis for women who have an intermediate or high risk of VTE in pregnancy, labour and post-natal period.

1.3. This version supersedes any previous versions of this document.

1.4. Please also note out of date information in the hand held notes risk assessment tools. For women with High/intermediate risk of VTE and with a low bleeding risk, if the woman accepts LMWH, she will not require anti-embolism stockings (AES). However, if the woman declines LMWH she will require anti-embolism stockings (AES).

1.5. Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can’t rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the ‘information use framework policy’, or contact the Information Governance Team rch-tr.infogov@nhs.net

2. **The Guidance**

2.1. **Assessment of risk:** Pregnancy, labour and delivery are associated with a tenfold increase in the risk of VTE.¹ Therefore all women should undergo a documented assessment of risk factors for VTE as follows:

2.2. **At booking**

2.2.1. Risk assessment for VTE will be performed, on all women, at booking. The pathway for referral should be followed as per the risk assessment tool, which is integral to the maternity hand held notes. (Appendix 3)

2.2.2. If referral to joint Obstetric and haematology clinic is required this should be completed by electronic referral within the EUROKING system, the process for which is out-lined in Appendix 4.

2.2.3. If a referral to a consultant clinic is required this should be recorded within the patient record in the EUROKING system.
2.3. **Antenatal inpatient admission**

2.3.1. All antenatal women admitted to RCH should automatically be considered for thrombo-prophylaxis if the risk of VTE outweighs the risk of bleeding (Appendix 5). The appropriate thrombo-prophylaxis should be prescribed, in discussion with the woman.

2.3.2. If using LMWH in pregnant women admitted to hospital, start it as soon as possible and within 14 hours of the risk assessment being completed and continue until the woman is no longer at increased risk of VTE or until discharge from hospital or midwife-led unit.

2.3.3. Where a woman’s overall VTE risk has been increased due to admission an appropriate referral should be made to the joint Obstetric and haematology clinic.

2.3.4. A baseline full blood count (FBC) result should be obtained for those who are started on low molecular weight heparin (LMWH). A repeat FBC is not necessary unless the woman develops rashes or becomes ill.

2.4. **Admission at labour/delivery**

2.4.1. Those women admitted for induction of labour, early labour and established labour will be exempt from risk assessment until post-delivery and should not be offered thrombo-prophylaxis.

2.4.2. If thrombo-prophylaxis has been given in the Antenatal period this should stopped at onset of labour.

2.5. **Post delivery**

2.5.1. After delivery a risk assessment for VTE and bleeding is to be made by the person conducting the delivery by completing the postnatal VTE risk assessment form, which is integral to the maternity hand held notes. (Appendix 6)

2.5.2. If intermediate or high risk this must be communicated to a doctor who will prescribe/offer appropriate prophylaxis in discussion with the woman, using the table on the back of the risk assessment proforma. (Appendix 7)

2.5.3. If the woman accepts prophylaxis a baseline FBC should be taken and the result obtained prior to administration of LMWH.

2.5.4. Consider combined prophylaxis with both LMWH and intermittent pneumatic compression for those patients who are expected to have significantly reduced mobility relative to their normal state post caesarean section. Use AES if IPC are contra-indicated.

2.6. **Women delivering at home or birthing centre**

All women regardless of the mode or place of delivery should be risk assessed. The midwife conducting the delivery should complete the risk assessment as above. Those women who are at high risk or intermediate risk of VTE should be offered prophylaxis for the recommended duration and if this is accepted it can
be prescribed by their GP or they may be referred to the day assessment unit (DAU) at RCHT within the next 24 hours or Wheal Rose if at the weekend.

2.7. **Women who are seen in the joint haematology obstetric clinic**
These patients will often have a previous history of VTE or a combination of background risk factors which means they may be indicated for both ante and post-natal prophylaxis with LMWH. Currently whilst there are no data to guide appropriate doses of LMWH for obese pregnant women VTE have been reported in overweight and obese patients receiving standard dose prophylaxis and therefore consideration should be given for prophylaxis at the following doses:

<table>
<thead>
<tr>
<th>Weight at booking</th>
<th>LMWH prophylaxis dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50kg</td>
<td>2500 units</td>
</tr>
<tr>
<td>50-90Kg</td>
<td>5000 units</td>
</tr>
<tr>
<td>90-130Kg</td>
<td>7500 units*</td>
</tr>
<tr>
<td>&gt;130kgs</td>
<td>10000 units*</td>
</tr>
</tbody>
</table>

*These doses are currently unlicensed. Women receiving doses above 5000 units should not have an epidural site until 24 hours after their last dose of LMWH. Where there is a strong indication that the patient wishes to have regional anesthesia for labour consideration should be given to reduce the dose to 5000 units daily in the week prior to delivery which will enable epidural siting 12 hours after last LMWH administration.

All decisions made in the joint haematology obstetric clinic regarding prophylaxis will be documented as per section 2.9 below.

2.8. **The first dose of LMWH can be given:**
- When result of FBC received and platelets are greater than 75
- When there is no active bleeding
- After 4 hours of epidural catheter removal and spinal.
- Then daily following the first dose

2.9. **Documentation of management plans for VTE or thromboprophylaxis**

2.9.1. For women seen at the joint obstetric/haematology clinic a letter will be added to the patient’s EUROKING electronic maternity record which can be accessed by the midwife, consultant obstetrician and consultant anaesthetist. A copy of this letter will also be sent to the woman’s GP informing them of the plan of care.

2.9.2. The plan of care should also be documented on the ‘maternity management plan’ page of the maternity hand held notes.

2.9.3. For women seen by the consultant obstetrician team either as an outpatient or as ante-natal inpatient the plan of care should also be documented on the ‘maternity management plan’ page of the maternity hand held notes.

2.9.4. Any management plan which relates to labour, delivery and the post-natal period should be copied to the ‘risk file’ on delivery suite.
### 3. Monitoring compliance and effectiveness

| Element to be monitored | The audit will take into account record keeping by obstetricians and midwives  
| | The results will be inputted onto an excel spreadsheet  
| | The audit will be registered with the Trust’s audit department  
| Lead | Audit Midwives  
| Tool | Was a booking risk assessment completed?  
| | If an ante natal admission (non labour related) was a risk assessment completed  
| | Was a post-delivery risk assessment completed  
| | If assessed as intermediate or high was the appropriate referral made to the joint haem/obs team or consultant clinic  
| | If the woman required thromboprophylaxis was an appropriate management plan documented in her notes  
| Frequency | 1% or 10 sets, whichever is the greater, of all health records of women who have delivered following thromboprophylaxis during the antenatal and/or post-natal period will be audited over a 12 month period  
| Reporting arrangements | A formal report of the results will be received annually at the maternity risk management and clinical audit forum, as per the audit plan  
| | During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next maternity risk management and clinical audit forum and an action plan agreed.  
| Acting on recommendations and Lead(s) | Any deficiencies identified on the annual report will be discussed at the maternity risk management and clinical audit forum and an action plan developed  
| | Action leads will be identified and a time frame for the action to be completed by  
| | The action plan will be monitored by the maternity risk management and clinical audit forum until all actions complete  
| Change in practice and lessons to be shared | Required changes to practice will be identified and actioned within a time frame agreed on the action plan  
| | A lead member of the forum will be identified to take each change forward where appropriate.  
| | The results of the audits will be distributed to all staff through the risk management newsletter/audit forum as per the action plan  

### 4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

4.2. **Equality Impact Assessment**  
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Venous Thromboembolism during Pregnancy, Labour and the Post-partum Period Risk Assessment Clinical Guideline V2.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>October 2019</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>December 2019</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>November 2021</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Carrie Gray  
DVT Clinic Manager  
Mr Andrew McSorley  
Thrombosis specialist Nurse |
| Contact details: | 01872 25 35 97 |
| Brief summary of contents | This gives guidance to midwives and obstetricians in the timing of risk assessments for Venous Thromboembolism (VTE) during pregnancy, labour and post-natal period and the referral pathway for those women identified as being at risk  
This gives guidance to obstetricians on the planning and prescribing of thromboprophylaxis for women who have an intermediate or high risk of VTE in pregnancy, labour and post-natal period. |
| Suggested Keywords: | VTE risk assessment, thromboprophylaxis |
| Executive Director responsible for Policy: | Medical Director |
| Date revised: | October 2019 |
| This document replaces (exact title of previous version): | Venous Thromboembolism during Pregnancy, Labour and the Post-partum Period Risk Assessment Clinical Guideline V2.1 |
| Approval route (names of committees)/consultation: | Maternity guidelines group  
Obs and Gynae directorate meeting  
TPAS (VTE policy) steering group. |
| Care Group General Manager confirming approval processes | Debra Shields, Care Group Manager |
| Name and Post Title of additional signatories | Not required |
**Name and Signature of Care Group/Directorate Governance Lead confirming approval by specialty and care group management meetings**

{Original Copy Signed}

Name: Caroline Amukusana

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**Signature of Executive Director giving approval**

{Original Copy Signed}

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**Publication Location (refer to Policy on Policies – Approvals and Ratification):**

Internet & Intranet ✔️ Intranet Only

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**Document Library Folder/Sub Folder**

Clinical / Midwifery and obstetrics

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**Links to key external standards**

CNST 3.8

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**Related Documents:**

- Confidential enquiry into maternal and child health. (Dec 2007) *Saving mothers lives. The seventh report*. CEMACH. London
- RCHT July 2012: *clinical guideline for booking, ante natal care and information giving’*

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**Training Need Identified?**

No

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**Version Control Table**

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2007</td>
<td>1.0</td>
<td>Initial document</td>
<td>Dr Aylur Rajasri Consultant Obstetrician</td>
</tr>
</tbody>
</table>

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*Venous Thromboembolism during Pregnancy, Labour and the Post-partum Period Risk Assessment Clinical Guideline V2.2*
<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Change Description</th>
<th>Author/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2011</td>
<td>1.1</td>
<td>Updated in line with new RCOG guidance and added compliance monitoring</td>
<td>Dr Aylur Rajasri Consultant Obstetrician</td>
</tr>
<tr>
<td>October 2012</td>
<td>1.2</td>
<td>Change to compliance monitoring only</td>
<td>Dr Aylur Rajasri Consultant Obstetrician</td>
</tr>
<tr>
<td>May 2016</td>
<td>1.3</td>
<td>Updated in line with new RCOG guidance</td>
<td>Mr Andrew McSorley Thrombosis Practitioner VTE/CNS</td>
</tr>
<tr>
<td>Nov 2018</td>
<td>2.0</td>
<td>Updated in line with NICE 89 guidelines</td>
<td>Mr Andrew McSorley Thrombosis Practitioner VTE/CNS</td>
</tr>
<tr>
<td>October 2019</td>
<td>2.1</td>
<td>Review of document but no additions required to ensure that BMI is based upon the measurement taken at the dating scan</td>
<td>Sarah-Jane Pedler, Practice Development Midwife</td>
</tr>
<tr>
<td>November 2019</td>
<td>2.2</td>
<td>Appendixes 3 to 5 included as per version V2.0 previously.</td>
<td>Mr Andrew McSorley Thrombosis Practitioner VTE/CNS</td>
</tr>
</tbody>
</table>

**All or part of this document can be released under the Freedom of Information Act 2000**

**This document is to be retained for 10 years from the date of expiry.**

**This document is only valid on the day of printing**

**Controlled Document**

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.
## Appendix 2. Initial Equality Impact Assessment Form

Name of the strategy / policy / proposal / service function to be assessed
Venous Thromboembolism during Pregnancy, Labour and the Post-partum Period Risk Assessment Clinical Guideline V2.2

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>New or existing document:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obs and Gynae Directorate</td>
<td>Existing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of individual completing assessment:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew McSorley</td>
<td>01872 253597</td>
</tr>
</tbody>
</table>

### 1. Policy Aim*
Who is the strategy / policy / proposal / service function aimed at?
To give guidance to midwives and obstetrician on risk assessing for VTE and management of thromboprophylaxis

### 2. Policy Objectives*
Ensure women at risk of VTE are identified and managed

### 3. Policy – intended Outcomes*
Prevention of VTE in pregnant woman

### 4. *How will you measure the outcome?*
Compliance monitoring tool

### 5. Who is intended to benefit from the policy?
Pregnant women

### 6a Who did you consult with

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

b). Please identify the groups who have been consulted about this procedure.
TPAS (VTE policy) steering group

What was the outcome of the consultation?
Guideline agreed

### 7. The Impact
Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.  
   Yes   No   X

9. If you are **not** recommending a Full Impact assessment please explain why.

Not indicated

| Date of completion and submission | October 2019 | Members approving screening assessment | Policy Review Group (PRG) |
|                                  |             |                                        | APPROVED                 |

This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

A summary of the results will be published on the Trust’s web site.
Appendix 3. Antenatal VTE Risk Assessment And Management At Booking

(This page to be completed at booking by Community Midwife)

Place of risk assessment:………………………………………
Date: ………………………… Gestational age:…………………………

Thrombosis risk:

- Any previous VTE except for a single event related to major surgery
- Hospital admission
- Single previous VTE related to major surgery
- High risk Thrombophilia* + no VTE
- Ovarian hyperstimulation
- Significant medical Co-morbidities e.g. cancer, Heart / lung / kidney disease, SLE / inflammatory bowel disease / sickle cell / IVDU

**HIGH RISK**
- Requires ante-natal prophylaxis with LMWH
- **Refer to Combined Obstetric-Haematology clinic

**INTERMEDIATE RISK**
- Consider antenatal thrombo-prophylaxis with LMWH
- **Offer referral to Combined Obstetric Haematology clinic for advice (appointment or letter of advice will be sent on case to case basis). For significant medical co-morbidities refer to relevant Consultant clinic.

≥3 risk factors

- Age > 35 years
- Obesity (BMI > 30)
- Parity 3 or more
- Smoker
- Gross Varicose veins
- Current pre-eclampsia or pregnancy induced hypertension
- Current systemic infection
- Immobility more than 3 days/ Long haul flight > 4 hours within 2 weeks
- Dehydration, hyperemesis
- Multiple pregnancy or IVF
- Family history of VTE

4 OR MORE RISKS:
- Prophylaxis from first trimester

3 OR MORE RISKS:
- Prophylaxis from 28 weeks
- **Refer patient to Combined Obstetric-haematology clinic.

<3 risk factors

- Mobilisation and avoidance of dehydration

Outcome: Low / Intermediate / High-

Referral: Sent/Referral Declined

Signature…………………………..Name…………………………………..Date……………………

*Thrombophilia is defined tendency to thrombosis (e.g. Factor V Leiden, antiphospholipid antibodies
**Referral to the Combined Obstetric Haematology Clinic should be made by completing Euroking Heam-obs referral (see appendix 4)

The Euroking system contains the functionality to create and complete an electronic Haematology-obstetric referral for patients to the joint haematology-obstetric clinic. The process for referral is outlined below

Creating a Haem-Obs referral Form

**Step 1:** Access the patient record by using the Patient Search window; open the patient current pregnancy record and select past medical and surgical history
Step 2: Select **Thrombo-embolic disorder** and the screen will display options for selection which can be completed depending on patient history.
Step 3: Select current pregnancy option within patient’s current pregnancy record.
Step 4: History of VTE section can be completed with patient’s history where relevant.
Step 5: Haematology Disorders (VTE) can also be populated if there are other non-VTE haematological disorders which may require a joint clinic review (i.e. Thrombocytopenia)
Step 6: Additional associated VTE risks can also be completed in the associated risks section
Step 7: Once all background clinical details have been entered in step 1-6 above then select referrals section in the record and complete the section for Haem/Obs clinic. Once completed this will generate an automatic referral to the thrombosis service for actioning
Appendix 5. Antenatal VTE Prophylaxis Management on Admission (Excluding labour/induction of labour)

All pregnant women admitted to hospital (including to the gynaecology ward with hyperemesis gravidarum or Ovarian hyperstimulation syndrome) should be offered thrombo-prophylaxis with LMWH unless there is a specific contra-indication such as risk of labour or bleeding (see below)

- Assess bleeding risk as follows and withhold LMWH if one of the following identified
  - Platelets<75, Inherited bleeding disorders
  - Active bleeding: Placenta praevia/ abruption
  - Uncontrolled blood pressure (200/110), Acute Fatty liver, HELLP with low platelets
  - Induction of labour, delivery or regional analgesia expected within 12 hours

If LMWH prescribed- Dose and duration (please specify)..............................

Drug chart checked/ woman informed (please circle)

FBC checked/ performed before prescription (please circle)

**Dosage of LMWH (Dalteparin) for VTE prophylaxis:** Dose depends on booking weight

<table>
<thead>
<tr>
<th>Booking Weight</th>
<th>Dose daily, S/C</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 50kg</td>
<td>2,500 units</td>
</tr>
<tr>
<td>50 – 90 kg</td>
<td>5,000 units</td>
</tr>
<tr>
<td>90 – 130 kg</td>
<td>7,500 units</td>
</tr>
<tr>
<td>130+ kg</td>
<td>10,000 units</td>
</tr>
</tbody>
</table>

**Epidural / spinal analgesia:** Placement or removal of catheter should be delayed for 12 hours after administration of LMWH. LMWH should not be given sooner than 4 hrs after catheter removal.

Women admitted for APH are at risk of bleeding and hence will not qualify for pharmacological prophylaxis with Fragmin irrespective of the degree of risk for VTE and will receive only TEDS / mobilisation/ hydration after risk stratification until the bleeding risk has subsided.

Signed............................ Name............................................. Date............................

Designation (SHO/ REG/ STAFF GRADE/ CONSULTANT)
Appendix 6. Postnatal VTE Assessment

(To be completed after delivery by person conducting the delivery)

Place of risk assessment………………………………………..Date…………………………

- Any previous VTE
- Anyone requiring antenatal LMWH
- High risk thrombophilia
- Low risk Thrombophilia + family history of VTE
- Caesarean section in labour
- BMI > 40
- Re-admission or prolonged hospital admission>3 days
- Medical Co-morbidities eg. Heart or lung disease, SLE, Cancer, inflammatory conditions, sickle cell disease, nephrotic syndrome, IVDU
- Age > 35 years
- Obesity (BMI > 30)
- Parity ≥3
- Smoker
- Family history of VTE
- Elective Caesarean section
- Gross Varicose veins
- Current systemic infection
- Immobility (SPD/ Long distance travel
- Current Pre-eclampsia
- Operative delivery (other than "lift out")
- Prolonged labour (>24 hours)
- Pre-term delivery <37 weeks
- PPH of >1litre or blood transfusion
- Still – birth in this pregnancy

**HIGH RISK**
- Prescribe at least 6 weeks postnatal prophylactic LMWH
- Advise mobilisation + avoidance of dehydration
- Refer to Combined Obstetric-Haematology clinic for postnatal follow up if not already done so

**INTERMEDIATE RISK**
- Advise LMWH prophylaxis for at least 10 days postnatal
- Advise mobilisation + avoidance of dehydration
- Consider extending thrombo-prophylaxis beyond 7 days if immobility persists or > 3 risk factors below

**LOW RISK**
- Early Mobilisation and avoidance of dehydration

VTE Risk Assessment: - Low/Intermediate/High (please circle)
Signature………………………………………..Name………………………………………..Date
Appendix 7. VTE Assessment and Management After Delivery-Outcome

(To be filled by the Middle grade/ SHO/ Consultant on call on delivery suite)

<table>
<thead>
<tr>
<th>Risk of VTE- please tick</th>
<th>Thromboprophylaxis</th>
</tr>
</thead>
</table>
| High/intermediate risk of VTE (with low bleeding risk) | • LMWH  
• early mobilisation  
• adequate hydration |
| High/intermediate risk of VTE (with significant risk of bleeding or declines fragmin) | • TEDS stockings  
• early mobilisation  
• adequate hydration |
| Low risk of VTE | • Early mobilisation  
• adequate hydration |

If LMWH prescribed- Dose and duration (please specify)…………………………

Drug chart checked/ woman informed (please circle)

FBC checked / performed before prescription (circle)

**Dosage of LMWH for VTE prophylaxis:** Dose depends on booking weight

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 50 kg</td>
<td>2,500 units daily, S/C</td>
</tr>
<tr>
<td>50 – 90 kg</td>
<td>5,000 units daily, S/C</td>
</tr>
<tr>
<td>90 – 130 kg</td>
<td>7,500 units daily, S/C</td>
</tr>
<tr>
<td>130+ kg</td>
<td>10,000 units daily, S/C</td>
</tr>
</tbody>
</table>

**Epidural / spinal analgesia:** Placement or removal of catheter should be delayed for 12 hours after administration of LMWH. LMWH should not be given sooner than 4 hrs after catheter removal.

If woman delivered at home or in birthing centre and accepts LMWH – refer to DAU for FBC & Prescription

There is no need to repeat FBC for 10 days prophylactic LMWH, unless the woman reports with rashes.

Signed……………………………………………..Name…………………………………………………………...

Date………………………………………………..

Designation (SHO/ REG/ STAFF GRADE/ CONSULTANT)