Thromboprophylaxis in the Antenatal, Intrapartum and Postnatal Period (VTE)

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The latest approved version of this document is online.
If the review date has passed, please contact the Author for advice.

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	July 2023

Table of Contents

ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Midwife
Consultant midwife/Interim Head of Midwifery
Perinatal Local Safety Champion

Circulated to the following for Consultation

Date	Role / Designation
19/05/2023	Powys Midwives
19/05/2023	Midwifery Leadership and Management Team
19/05/2023	Women and Children's Guidelines Group Members
19/05/2023	Safeguarding Team
19/05/2023	Assistant Medical Director
19/05/2023	Medicines Management Team
19/05/2023	Link Obstetrician ABUHB, HDUHB, CTMUHB, SBUHB, BCUHB, SaTH, WVT

Date	Group Approved at
05/06/2023	Maternity Guidelines group
19/06/2023	Women & Children's Policies and guideline group

Evidence Base
Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area? Nice Guideline (2021). Antenatal Care (NG201) RCOG (2015). Reducing the Risk of Thrombosis and Embolism during Pregnancy and the Puerperium (Green-top Guideline No. 37a) NICE Guideline (NG89) (2018) Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism

IMPACT ASSESSMENTS

Equality Impact Assessment Summary					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** Please remember policy documents are published to both the **intranet** and **internet.** The version on the internet must be translated to Welsh.
Age	X				
Disability	X				
Gender reassignment	X				
Pregnancy and maternity	X				
Race	X				
Religion/ Belief	X				
Sex	X				
Sexual Orientation	X				
Marriage and civil partnership	X				
Welsh Language	X				
Human Rights	X				

Risk Assessment Summary
Have you identified any risks arising from the implementation of this policy / procedure / written control document? No risks identified
Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document? As above
Have you identified any training and / or resource implications as a result of implementing this? Introduction of new paperwork, training to be disseminated

1. Introduction

Pregnancy is known to increase the risk of venous thromboembolism (VTE), the risk is increased by approximately 4-6 times that of a non-pregnant population. This risk commences with the start of pregnancy (the first trimester) and continues throughout pregnancy. The risk of VTE is significantly higher again in the postnatal period, a noted increase in risk in the first week following birth.

VTE remains one of the leading causes of maternal morbidity and mortality. The MBRRACE-UK report found that in 2018 – 20 there were 29 deaths from VTE, 1.38 deaths per 100,000 maternities. The maternal mortality rate from VTE remains at a similar rate to 2015- 17, suggesting that several of these deaths could be prevented with improvements to care.

This guideline explores the risk assessment, prevention, investigation, and management of suspected or proven VTE in pregnancy and the postnatal period.

2. Aim and Objective

To provide information and guidance based on the most relevant evidenced based information regarding the recognition of risk and the immediate investigation, management and ongoing care planning of those women that are at greater risk of venous thromboembolism; or for those women where venous thromboembolism is suspected in pregnancy, intrapartum or in the post-natal period.

To reduce the risks of pregnant and postpartum women experiencing preventable thrombosis such as pulmonary embolism (PE) and deep vein thrombosis (DVT) by effective risk assessments and initiation of low molecular weight heparin (LMWH). VTE remains one of the leading causes of maternal morbidity and mortality. The MBRRACE-UK report found that in 2018 – 20 there were 29 deaths from VTE, 1.38 deaths per 100,000 maternities. The maternal mortality rate from VTE remains at a similar rate to 2015- 17, suggesting that several of these deaths could be prevented with improvements to care.

To use this guidance in conjunction with NICE guidance: Antenatal Care (2021) and RCOG (2015): Reducing the Risk of Thrombosis and Embolism during Pregnancy and the Puerperium (Green-top Guideline No. 37a) (Appendix A) to appropriately risk assess, prevent, monitor, and deliver the most appropriate care in pregnancy, intrapartum and postnatal period.

To work in unison with the obstetric team where appropriate, to maintain appropriate documentation, make appropriate referral and continue to effectively monitor well-being throughout pregnancy and the postnatal period.

3. Definitions

- **PTHB** – Powys Teaching Health Board
- **LMWH**- Low molecular weight heparin
- **CLC**- Consultant led care
- **MLC**- Midwifery led care
- **MDT**- Multi disciplinary team
- **ART**- Assisted Reproductive Technology
- **BMI**- Body Mass Index
- **CEMACH**- Confidential Enquiries into Maternal and Child Health
- **CMACE**- Centre for Maternal and Child Enquiries

- **MBRRACE** - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
- **DVT-** Deep vein thrombosis
- **IOL-** Induction of labour
- **IVF-** In vitro fertilisation
- **OHSS-** Ovarian Hyper stimulation syndrome
- **PE-** Pulmonary Embolism
- **VTE-** Venous Thromboembolism
- **SLE –** Systemic lupus erythematosus
- **IBD –** Inflammatory bowel disease

4. Responsibilities

4.1 Head of Midwifery and Sexual Health

The Head of Midwifery and Sexual Health must:

- Ensure all staff read and understand this guideline
- Arrange regular review to monitor compliance with this guideline

4.2 Assistant Head of Midwifery and Sexual Health Services

The Assistant Head of Midwifery and Sexual Health Services has responsibility for:

- Ensuring dissemination of this document to all relevant staff
- Liaising with District General Hospitals (DGH) to feedback where care has fallen outside of this guideline

4.3 Band 7 operational team lead (OTL)

The OTL has responsibility for:

- Ensuring compliance with this document by the teams that they manage

4.4 Consultant Midwife

The consultant midwife has responsibility for:

- Supporting implementation of this document
- Reviewing any new evidence or guidance that is produced that may influence the service
- Communicating any key changes in advice that might influence service provision to the Midwifery Leadership and Management team for consideration.
- Being available in an advisory capacity related to care outside of guidance
-

4.5 Women and Children's Risk and Governance Lead

The Women and Children's Risk and Governance Lead has responsibility for:

- Monitoring review of incidents in relation to content of this document

4.6 All Staff working within maternity services

All staff working the maternity services have responsibility for:

- Reading and being familiar with contents of this document
- Referring women appropriately for additional care where required
- Working to the requirements of their role within the scope of this guideline

5. Assessment in the antenatal period

All women will be assessed using the maternity Venous thromboembolism (VTE) risk assessment tool for the risk of VTE at the following times:

- Initial booking visit with named midwife (repeated following dating scan if required)
- Antenatal contacts if intercurrent problems occur
- When presenting in labour
- Postpartum (prior to transfer home if a local birth) or
- Postnatally on first visit home (if birthed outside of Powys)

The antenatal VTE risk assessment tool should be reviewed at every antenatal contact to ensure no changes are required. If any changes occur, please complete a new VTE risk assessment tool.

Risk assessment should be conducted using the thromboprophylaxis risk assessment tool in Appendix B (antenatal) and Appendix C (postnatal).

VTE Risk Assessment Scoring

- If total score ≥ 4 antenatally, consider thromboprophylaxis from the first trimester.
- If total score 3 antenatally, consider thromboprophylaxis from 28 weeks.
- If total score ≥ 2 postnatally, consider thromboprophylaxis for at least 10 days
- If total score > 3 postnatally thromboprophylaxis may be extended for up to 6 weeks following an obstetric review
- Anyone requiring antenatal thromboprophylaxis, has a high-risk thrombophilia, or a low-risk thrombophilia and a family history should have 6 weeks postnatal LMWH

Where a need for thromboprophylaxis is identified in pregnancy, this should be discussed with the woman, and if consenting to treatment, a referral for obstetric review should be arranged.

Informed Choice

Women should receive a comprehensive consultation with their midwife/obstetrician in order to make a decision as to whether or not to accept thromboprophylaxis. This should be evidenced

based and balanced against the chance of venous thrombo-embolism (VTE). During this consultation consideration should be made regarding plan of care, place of birth and benefits of midwifery led settings for suitable women; this consultation should be re-visited throughout the antenatal period and appropriately documented in the management plan.

Role and Responsibilities

- It is the responsibility of the midwife to complete and review the VTE risk assessment tool at booking, continually throughout the antenatal period, in the intrapartum period and again postnatally; to document/update accordingly in the women's handheld records.
- All assessments should include date, score and whether thromboprophylaxis needs to be considered. The VTE Risk Assessment Tool should be filed in the woman's handheld notes.
- To make timely referrals as and when required.
- To liaise with the obstetric team as required and ensure that women that require prophylactic Low Molecular Weight Heparin (LMWH) are prescribed appropriately.
- This again should be documented in the women's handheld record and the management plan should be updated in both the antenatal and postnatal records so that plan of care is clear, and care is safe, effective, and appropriate.

6. Deep Vein Thrombosis (DVT)

In pregnancy left sided DVT is more common than right sided DVT. The classical features of a DVT such as swelling, pain and tenderness are unreliable in pregnancy and where there is a high suspicion of DVT an ultrasound should be sought as well as review from an obstetrician and/ or medical consultant/ registrar.

Pre-existing risk factors:

- Previous DVT
- High and low risk thrombophilia
- Heritable conditions
- Acquired conditions
- Medical comorbidities; cancer, heart failure, active systemic lupus erythematosus (SLE), inflammatory bowel disease (IBD) or inflammatory polyarthopathy (arthritis in 5 or more joints), Type 1 diabetes with nephropathy, nephrotic syndrome, sickle cell disease, current intravenous drug user
- Ovarian Hyperstimulation Syndrome (OHSS)
- Age >/= 35
- Obesity; BMI >30

- Parity >/= 3
- Smoker
- Gross various veins
- Immobility e.g. paraplegia, PGP

Obstetric risk factors:

- Multiple pregnancy
- IVF/ART
- Current pre-eclampsia
- Caesarean section
- Prolonged labour >24 hours
- Mid-cavity or rotational operative delivery
- Stillbirth
- Preterm birth
- Post-partum haemorrhage >1litre or requiring transfusion

Transient risk factors:

- Dehydration
- Hyperemesis
- Current systemic infection
- Long distance travel

Contraindications to LMWH use

- Known bleeding disorder (e.g. haemophilia, von Willebrand's disease or acquired coagulopathy)
- Active antenatal or postpartum bleeding
- Women considered at increased risk of major haemorrhage (e.g. placenta praevia)
- Thrombocytopenia (platelet count < 75 × 109/l)
- Acute stroke in previous 4 weeks (haemorrhagic or ischaemic)
- Severe liver disease
- Uncontrolled hypertension (blood pressure > 200 mmHg systolic or > 120 mmHg diastolic).
- Women at high risk of haemorrhage with risk factors including major antepartum haemorrhage, coagulopathy, progressive wound haematoma, suspected intra-abdominal bleeding and postpartum haemorrhage may be managed with anti-embolism stockings (AES), foot impulse devices or intermittent pneumatic compression devices. Unfractionated heparin (UFT) may also be considered.
- Women with previous or current allergic reactions to LMWH should be offered an alternative preparation or alternative form of prophylaxis
- Severe renal disease

7. Risk reduction for VTE

A. Mobilisation

All women should be encouraged to mobilise whether they are at home or a hospital inpatient. It is equally important to remain well hydrated, particularly for women experiencing prolonged labour.

B. High Risk Women

Those women considered as high risk for VTE in pregnancy should be commenced on antenatal thromboprophylaxis as early as possible. They will also receive obstetric led care. The plan of care and recommendations for postnatal plan should be fully documented in the women's handheld notes by the obstetric team.

C. Bleeding or onset of Labour

Women that are currently taking antenatal thromboprophylaxis should be informed to cease injections if labour commences or if any per vaginal bleeding occurs. Those women that were prescribed antenatal thromboprophylaxis for a persisting risk factor should be given a prescription for postnatal thromboprophylaxis.

D. Long term LMWH

Women that have been prescribed long term LMWH should be taught how to self-administer; it should not be expected that a community midwife is to administer, and this should only be considered in exceptional circumstances. Each woman should be given appropriate equipment for safe disposal of sharps and be aware of plans for removal when finished/ full.

8. Care for women in the intrapartum period who are at risk of VTE

Pregnant women who are receiving thromboprophylaxis should be informed of the following:

- There is increased chance of postpartum haemorrhage (PPH) of both >500mls and >1000mls with antenatal anticoagulants. This may exist even where this medication is in prophylactic doses and has not been received in the last 12-24 hours.

- Increased chance of PPH is seen in women administering prophylactic antenatal anticoagulation, but mean blood loss and blood transfusion are not thought to increase.

- There is a lack of evidence to firmly suggest that women on antenatal thromboprophylaxis should be advised to birth on an obstetric unit. More research is necessary in order to adequately support planning for place of birth in this group; however due to the probable increased chance of PPH, and the absence of evidence it seems an appropriate precaution.

- An active 3rd stage is recommended in any setting for those women receiving antenatal thromboprophylaxis.

- Where induction of labour or delivery is planned, LMWH is usually discontinued 24-hours before. A plan should be made with the obstetric team, balancing risk of haemorrhage from continued anti-coagulation with risk of a thrombo-embolic episode.

If a pregnant woman chooses to labour and birth in Powys, against medical advice in relation to use of thromboprophylaxis the following should be discussed and put in place:

- Discussion that the recommendation is for birth in an obstetric unit
- Offer of a review by an obstetrician to discuss risks and plan for birth in a low-risk setting
- Reference to the Clinical Information Sharing (CIS) Process (Appendix E) and compilation and circulation of a CIS document

9. Management of cases where postnatal thromboprophylaxis is required for MLC women birthing in Powys only

Where there is an antenatal VTE score of 2 or more, and postnatal thromboprophylaxis is accepted, midwives should follow the guidance provided below. The requirement for postnatal LMWH doesn't prevent a woman from birthing in Powys.

Where women are MLC but require postnatal thromboprophylaxis the following should be completed

- A referral to obstetric care in the antenatal period – which includes the VTE risk assessment tool (appendix B) and cover letter (appendix D)
- An obstetric review by 28/40 and a prescription completed by an obstetrician for postnatal LMWH
- A review of the VTE Risk Assessment Tool (antenatal and postnatal) at 36/40 by the community midwife to ensure LMWH has been prescribed appropriately for the postnatal period
- A demonstration by the community midwife to the women on how to administer LMWH at home
- Ensure a sharps bin has been provided for safe disposal of needles

Please note: the cover letter (appendix D) is for MLC women, wishing to birth in Powys that require postnatal thromboprophylaxis only

10. Assessment in the postnatal period

All women should have a further VTE risk assessment following birth.

This should include completing the VTE Risk Assessment Tool in the postnatal pathway either

- Postpartum (prior to transfer home if a local birth) or
- Postnatally on first visit home (if birthed outside of Powys)

Please note: the Postnatal VTE Risk Assessment Tool will be within the postnatal pathway

11. Acute identification and management

Any woman presenting to maternity services with symptoms of VTE will be referred to the nearest obstetric unit for a review, this may involve being reviewed in the emergency department.
Pregnant or postpartum women with symptoms and/or signs of VTE should have objective testing performed expeditiously in an obstetric unit and should be treated with LMWH until the diagnosis is excluded by objective testing unless treatment is strongly contraindicated.

12. Monitoring Compliance, Audit & Review

An audit will be conducted within the first year of use to assess use of the risk assessment tool (antenatally and postpartum) and appropriate referral for thromboprophylaxis through the annual record keeping audit.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

13. References / Bibliography

If you include a PTHB document, please ensure you have the document code and correct title.

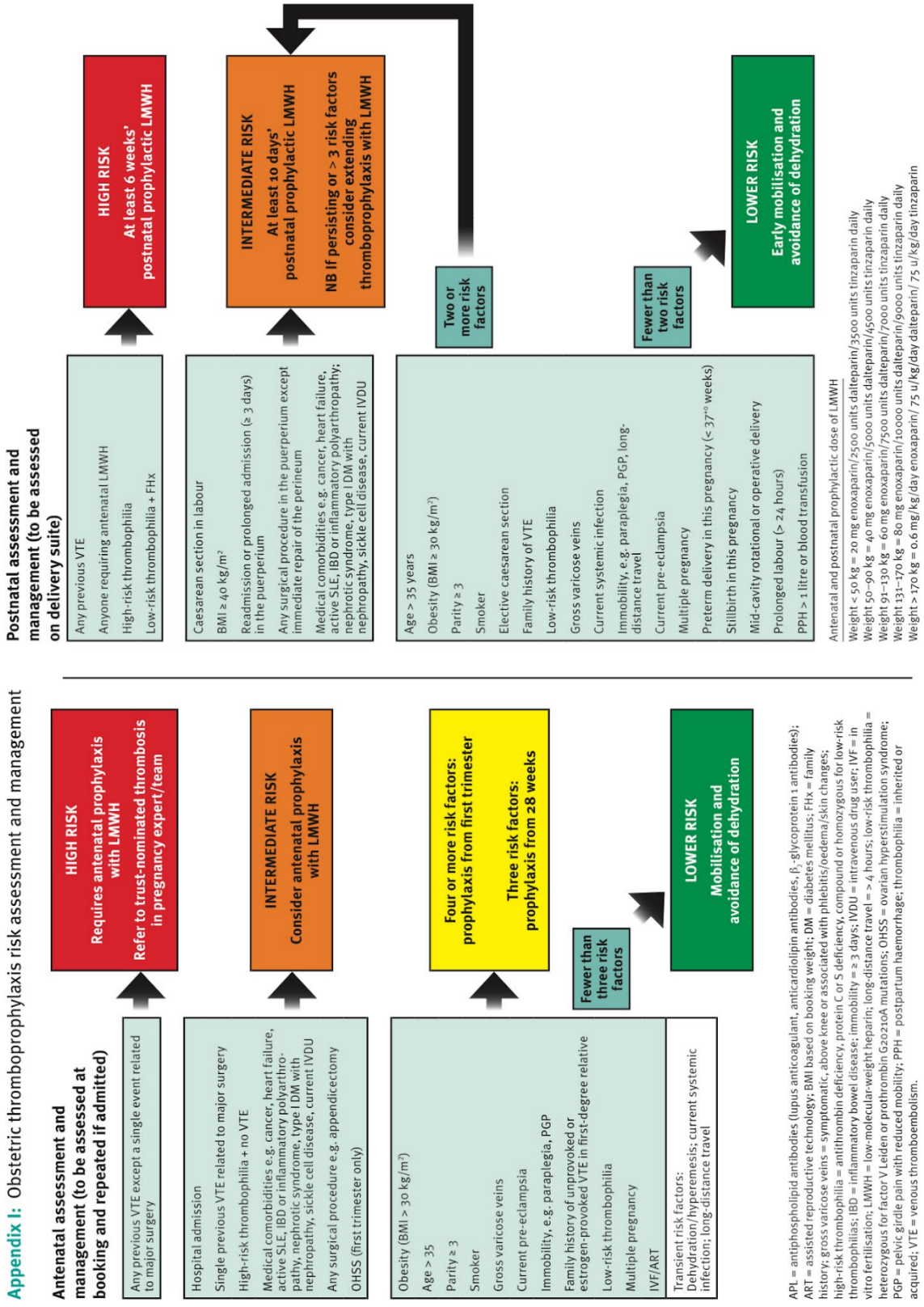
NICE Guideline (2021). Antenatal Care (NG201)

NICE Guideline (NG89) (2018) Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism

RCOG (2015). Reducing the Risk of Thrombosis and Embolism during Pregnancy and the Puerperium (Green-top Guideline No. 37a)

PTHB Mat 079 Informed Choice, Personalised Care and The Care Of Women Making Choice Outside Of Recommended Guidelines

Appendix A - RCOG – Risk Assessment and Management



Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Addressograph

Appendix B - Antenatal/Intrapartum VTE Risk Assessment Tool

	Tick	Gestation
Antenatal		
Intrapartum		

Pre – Existing Risk Factors	Tick	Score
Previous VTE (except a single event related to major surgery)		4
Previous VTE provoked by major surgery		3
Known high-risk thrombophilia		3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory polyarthropathy or inflammatory bowel disease; nephrotic syndrome; type I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user		3
Family history of unprovoked or oestrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)		1
Age (≥ 35 years)		1
BMI ≥ 40		2
BMI ≥ 30		1
Parity ≥ 3		1
Smoker		1
Gross Varicose Veins		1

Obstetric Risk Factors	Tick	Score
Pre-eclampsia in current pregnancy		1
ART/IVF		1
Multiple pregnancy		1
Stillbirth in current pregnancy		1

Transient Risk Factors	Tick	Score
Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum, e.g. appendicectomy, postpartum sterilisation		3
Hyperemesis		3
Ovarian Hyperstimulation Syndrome (First trimester only)		4
Current systemic infection		1
Dehydration or Immobility e.g. paraplegia, PGP, long distance travel		1
TOTAL		
Does thromboprophylaxis need to be considered?		

- If total score ≥ 4 antenatally, consider thromboprophylaxis from the first trimester
- If total score 3 antenatally, consider thromboprophylaxis from 28 weeks
- If total score ≥ 2 postnatally, consider thromboprophylaxis for at least 10 days

Indications for 6/52 postnatal LMWH	Tick
Previous history of confirmed VTE	
Anyone requiring antenatal LMWH	
Family history of VTE particularly pregnancy or hormone related and/or an identified thrombophilia	
Antithrombin deficiency	
Antiphospholipid syndrome	
High risk thrombophilia – Homozygous Factor V Leidens, Compound heterozygote Protein C or S deficiency	
Low risk thrombophilia – Factor V Leidens, prothrombin gene mutation	

Contraindications/cautions to LMWH use	
Known bleeding disorder (e.g. haemophilia, von Willebrand's disease or acquired coagulopathy)	
Active antenatal or postpartum bleeding	
Women considered at increased risk of major haemorrhage (e.g. placenta praevia)	
Thrombocytopenia (platelet count < 75 × 109 /l)	
Acute stroke in previous 4 weeks (haemorrhagic or ischaemic)	
Severe renal disease	
Severe liver disease	
Uncontrolled hypertension (blood pressure > 200 mmHg systolic or > 120 mmHg diastolic)	

Is Antenatal thromboprophylaxis required? Please make obstetric referral and document date sent.	
Does Postnatal thromboprophylaxis need to be considered?	
MLC wishing to birth in Powys – score of 2 or more and requires a postnatal prescription? Please make obstetric referral and document date sent.	

Where thromboprophylaxis needs to be considered please make a timely referral to obstetric care for a review of care.

If there is a score of 2 or more and the woman is MLC and plans to birth in Powys, please complete obstetric referral and MLC postnatal thromboprophylaxis cover letter to ensure LMWH is prescribed for the postnatal period.

Please document the VTE score and plan of care in the management plan of the maternity handheld notes and update as required.

If thromboprophylaxis has not been prescribed as recommended, please contact local DGH and liaise with the obstetric consultant to obtain suitable and timely prescription.

Notes

Signed:…… **Print**:…… **Date:**……..

GIG CYMRU NHS WALES | Bwrdd Iechyd Addysgu Powys | Powys Teaching Health Board

Addressograph

Appendix C - Postnatal VTE Risk Assessment Tool (To input in postnatal pathway)

To be completed at 36/40 birth plan:

Has a prescription been completed by the obstetric team if MLC and birthing in Powys with 2 or more risk factors?	
Has a LMWH administration demonstration been completed with the woman?	

To be completed postnatally:

	Tick	Days
Postnatal		

Pre – Existing Risk Factors	Tick	Score
Previous VTE (except a single event related to major surgery)		4
Previous VTE provoked by major surgery		3
Known high-risk thrombophilia		3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory polyarthropathy or inflammatory bowel disease; nephrotic syndrome; type I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user		3
Family history of unprovoked or oestrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)		1
Age (≥ 35 years)		1
BMI ≥ 40		2
BMI ≥ 30		1
Parity ≥ 3		1
Smoker		1
Gross Varicose Veins		1

Obstetric Risk Factors	Tick	Score
Pre-eclampsia in current pregnancy		1
Multiple pregnancy		1
Caesarean section in labour		2
Elective caesarean section		1
Mid-cavity or rotational operative delivery		1
Prolonged labour (> 24 hours)		1
PPH (> 1 litre or transfusion)		1
Preterm birth < 37+0 weeks in current pregnancy		1
Stillbirth in current pregnancy		1

Transient Risk Factors	Tick	Score
Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum, e.g. appendicectomy, postpartum sterilisation		3
Current systemic infection		1
Dehydration or Immobility e.g. paraplegia, PGP, long distance travel		1

TOTAL	
Does thromboprophylaxis need to be considered?	
Has this been prescribed appropriately?	

- If total score ≥ 2 postnatally, consider thromboprophylaxis for at least 10 days

Indications for 6/52 postnatal LMWH	**Tick**
Previous history of confirmed VTE	
Anyone requiring antenatal LMWH	
Family history of VTE particularly pregnancy or hormone related and/or an identified thrombophilia	
Antithrombin deficiency	
Antiphospholipid syndrome	
High risk thrombophilia – Homozygous Factor V Leidens, Compound heterozygote Protein C or S deficiency	
Low risk thrombophilia – Factor V Leidens, prothrombin gene mutation	

Contraindications/cautions to LMWH use	
Known bleeding disorder (e.g. haemophilia, von Willebrand's disease or acquired coagulopathy)	
Active antenatal or postpartum bleeding	
Women considered at increased risk of major haemorrhage (e.g. placenta praevia)	
Thrombocytopenia (platelet count < 75 × 109 /l)	
Acute stroke in previous 4 weeks (haemorrhagic or ischaemic)	
Severe renal disease	
Severe liver disease	
Uncontrolled hypertension (blood pressure > 200 mmHg systolic or > 120 mmHg diastolic)	

If thromboprophylaxis has not been prescribed as recommended, please contact local DGH and liaise with the obstetric consultant to obtain suitable and timely prescription.

Notes

Signed:…… **Print**:…… **Date:**……..

Appendix D - MLC Postnatal Thromboprophylaxis Cover Letter

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Birth Centre Address:

Date:

ADDRESSOGRAPH

Dear Doctor,

I have seen …….. today and have identified risk factors for VTE using our VTE Risk Assessment Tool, please find this attached to the letter which will provide you with further detail.

In accordance with RCOG: Reducing the Risk of Thrombosis and Embolism during Pregnancy and the Puerperium (Green-top Guideline No. 37a), this patient has a VTE score of 2 or more and postnatal thromboprophylaxis needs to be considered for at least 10 days.

Please note: This patient is midwifery led care and wishes to birth in Powys. This referral is for an obstetric review of the VTE Risk Assessment Tool and to kindly provide a prescription for LMWH for the postnatal period. Antenatal thromboprophylaxis is not required.

I have discussed the national guidance and the benefits of LMWH with the patient. I have carried out the VTE Risk Assessment Tool and found no contraindications to treatment.

Please could you kindly review this patient at 28/40, either face to face or via telephone and provide a prescription for LMWH for the postnatal period if appropriate.

Booking weight:

Booking BMI:

If you have any questions, please do not hesitate to contact a member of the midwifery team.

Kind Regards

Powys Midwife

Appendix E – CIS Process