Emergency Department / Respiratory Medicine

Patient with Pulmonary Embolism suitable for ambulatory care

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Name:
DoB:
(Affix Patient Label Here)

Hosp No.:
NHS No.:
Consultant:

To be completed by:

1. ED doctor who diagnosed PE and then re-assessed by ED middle grade or consultant *OR*
2. Respiratory middle grade/consultant in charge of patient's care

Date_____ Time_____

PE diagnosed on (circle)
CTPA
DVT on leg ultrasound and clinical PE
Other (e.g. V/Q)……

Results
D-dimer: …….micrograms/L Date:……
Troponin (HSTNT) …….nanograms/L Date:……
Creatinine …….micromol/L Date:……

Renal function: calculated creatinine clearance

$$CrCl = \frac{(140 - age.....) \times weight\ (kg).....}{Serum\ Creatinine\ (micromol/L)\ .....} \quad \begin{matrix} \textbf{X 1.04 (female)} \\ \textbf{X 1.23 (male)} \end{matrix} = ... (mL/min)$$

PESI SCORE:

Criteria All observation values should be first measured in department pre-treatment	**Score**	
Age	1 point per year	
Male gender	10	
Active cancer within 6 months	30	
History of heart failure	10	
History of chronic lung disease	10	
Pulse ≥110 bpm	20	
Systolic BP <100 mmHg	30	
Respiratory rate ≥30 bpm	20	
Temperature <36°C	20	
Altered mental status (disorientation, lethargy, stupor, or coma)	60	
Arterial oxygen saturation < 90%	20	
	Total score:	

Assessment of suitability for ambulatory care:	**Yes***	**No**
PESI score >85		
Troponin (HSTNT) ≥18		
Right ventricle dilated on CTPA		
Calculated creatinine clearance <30ml/min		
Pain inadequately controlled		
Inadequate social support		
Any other reason for admission		
Discharge from hospital/department between 8pm and 8am		

*** If "yes" to <u>any</u> question, then patient is <u>not</u> suitable for ambulatory care**

Ambulatory care patients must have been given the following (*tick when completed)*:

- Supply of therapeutic dose dalteparin (until seen in clinic) ☐ ***or*** rivaroxaban (21 day pack) ☐
- Patient counselling and written information ☐
- Appointment to attend STH Thrombosis Service (via Anticoagulation Clinic) within 72 hours ☐

DVT CDU nurse Signature:_____ Name:_____ Date:_____

ED or Respiratory middle grade/consultant
Signature::_____ Name:_____ Date:_____

ED: Refer patient to Thrombosis Nurse (via Anticoagulation Clinic) using diary booking system.
All other areas: fax this form and Anticoagulation Referral Form A to ext 68690.

Key: < = less than; ≤ = less than or equal to; > = more than; ≥ = more than or equal to

PRC number 18/014
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Approved by STH Thrombosis Committee January 2014 Issue date: April 2014 Review date: April 2017