Patient Sticker

Kingston Hospital NHS
NHS Foundation Trust

Pulmonary Embolism Ambulatory Emergency Care Pathway

Authors: Sophie O'Brien, Catie Paterson, Andrew Mitchell

Ambulatory Emergency Care (AEC) Unit

Open: **Monday – Friday 10am – 6pm**

Consultant: Dr M Oldfield Consultant: Dr D Harris Lead Nurse: Catie Paterson	**Direct Line: 0771 580 8241** **Land Line: 0208 934 3883** **Fax: 0208 934 3884**	Medical On Call Team SPR: 174 SHO:172/173

PE Pathway Summary

Patient From
ED (Emergency Department)
KHT Ward
KHT OPD
GP

ASSESSMENT

Observations:	**Bloods:**	**Tests:**
T	U&E	ECG
P	FBC	CxR
BP	CRP	
RR	D-Dimer	
O_2 Sats	LFT	

EXCLUSION CRITERIA

Unable to attend appointments

At risk of bleeding if anticoagulated

Pregnancy (if over 18/40 weeks gestation refer to obstetrics on call)

Patient on Warfarin already

PESI class III, IV or V (see clinical probability assessment, pages 3,4)

Exclusion criteria from clinical probability assessment, (pages 3,4)

Complete PE Clinical Probability Assessment (pages 3 and 4)

ED Actions (Page 5)

PE Treatment (Page 9)

Ambulatory Emergency Care (AEC)

IN HOURS AEC **10:00 – 17:00, Mon-Fri**	**OUT OF HOURS ED** **17:00 – 10:00**
Discuss with AEC if able to take patient for initial treatment	Commence initial treatment in ED (page 5)
Patient to take own notes	Patient to take own notes
If patient referred from GP AEC Doctor to complete Clinical Probability Assessment (pages 3 and 4)	Book appointment for patient in AEC
	Notes in AEC trolley in ED

Patient Sticker

PE Clinical Probability Assessment

Patient Contact Telephone Number _____

Date _____

Pregnancy Test		**Weight**	

BP ____ Pulse _____ RR _____ Temp _____ SaO2 on air (**post exertion**)_____

PREDISPOSING FACTOR Yes or No

Contraceptive pill	Y	N	Malignancy/Cancer	Y	N
Pregnancy or <6/52 post partum	Y	N	Air travel >4hrs in previous 4/52	Y	N
Surgery in last 4/52	Y	N	Bedbound	Y	N
Previous VTE	Y	N	Family Hx of VTE	Y	N
Known Thrombophilia	Y	N	Obesity	Y	N
Smoker	Y	N	IVDU	Y	N

Clinical Pre-test Probability (PTP) for PE (Wells Score)	**Points**	**Score**
PE is most likely diagnosis	3	
Clinical symptoms/signs of DVT (swelling/pain)	3	
HR>100bpm	1.5	
Immobilisation>3/7 or surgery within previous 4 weeks	1.5	
Previous DVT / PE	1	
Haemoptysis	1	
Active Malignancy (on Rx within past 6/12 or palliative)	1	
Probability of PE (Low <2 Moderate 2 - 6 High > 6)	**Total**	

If Wells score is high, D-dimer Not indicated **If Moderate & Low Wells score, D-dimer Indicated**

D-dimer _____ <0.3 Troponin _____ < 0.05

FBC		**Coag**			**U&E**		**LFT**	
Hb		INR			Na		Bili	
WBC		APTR			K		Alb	
PLT		BloodGas			Urea		ALT	
CRP		BHCG			Cr		ALP	

CXR _____ **ECG** _____

_____ _____

If Wells score is low/ moderate & D-dimer is negative no further investigations are required.
Further imaging using most appropriate modality to minimise exposure (PE imaging form to Radiology)
Please do not request a diagnostic investigation without conducting a risk assessment. If you wish to deviate a patient, consult a senior clinician

INVESTIGATIONS

Doppler _____	**CTPA/VQ** _____

Authors: Sophie O'Brien, Catie Paterson, Andrew Mitchell

Patient Sticker

PE Clinical Probability Assessment

PULMONARY EMBOLISM SEVERITY INDEX *(PESI*)

VARIABLE	POINTS	SCORE
Age	1/ year	
Male sex	10	
Cancer	30	
Heart Failure	10	
Chronic lung disease	10	
Heart rate 110bpm	20	
Systolic blood pressure 100 mmhg	30	
Respiratory rate ≥30 breaths/min.	20	
Body temperature 36 c	20	
Disorientation, lethargy,stupor,coma	60	
SaO2 ≤90%	20	
Total		

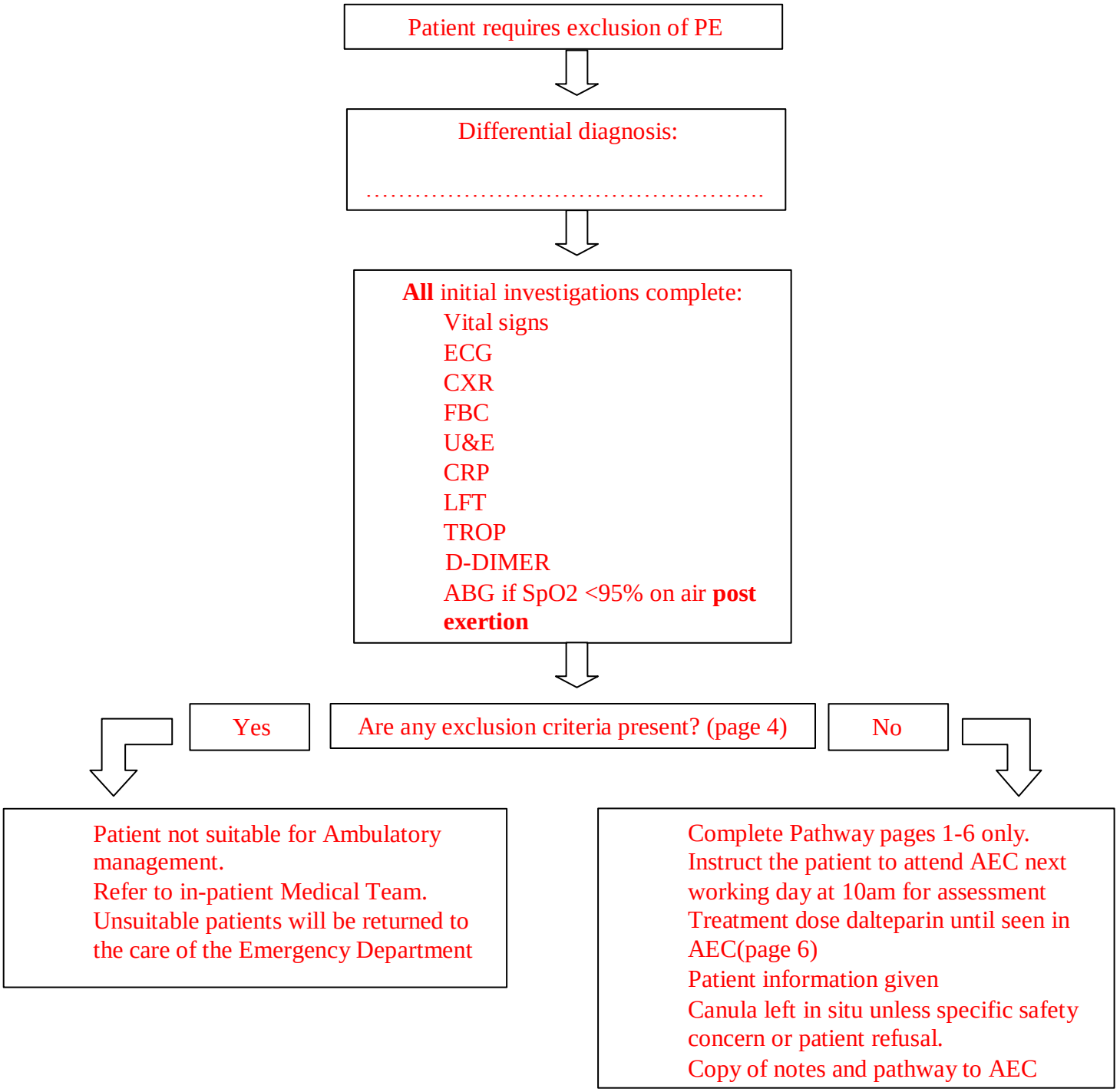
PESI RISK CLASSES

RISK CLASSES	SCORE	Mortality	√
CLASS I	<65 Very low risk	0%	
CLASS II	66-85 Low risk	1%	
CLASS III	86-105 Intermediate	3.1%	
CLASS IV	106-125 High risk	10.4%	
CLASS V	>125 Very high risk	24.4%	

EXCLUSION CRITERIA FOR AMBULATORY MANAGEMENT

Pulse >110bpm	Y	N	Coexisting major DVT being treated	Y	N
Systolic BP ≤100mmHg	Y	N	Right ventricular strain on 12lead ECG/Troponin positive	Y	N
Age <18	Y	N	Chronic lung disease	Y	N
Bleeding disorder	Y	N	Heart failure	Y	N
Active bleeding in last 4/52	Y	N	Significant comorbidity e.g. renal malignancy	Y	N
Creatinine ≥150umol	Y	N	Not registered to a GP/Live out of area	Y	N
Platelets ≤90	Y	N	Language difficulties	Y	N
Heparin allergy or HIT	Y	N	Social circumstances or unaccompanied at home	Y	N
Cerebrovascular disease	Y	N	Anticipated compliance problem	Y	N
Altered mental state (acute or chronic)	Y	N	Unable to walk	Y	N

Emergency Department Actions



NB. Clinical responsibility for the patient remains with the referrer until assessed in AEC

I confirm that I have assessed the patient and found them suitable for management in accordance with this pathway

Name…… Date……..... Signature……

Dalteparin (Fragmin) Dosing Guidelines

Dalteparin should be given for a **minimum of 5 days** and continued until the INR is **within** the therapeutic range (i.e. 2.0-3.0 or 3.0-4.0)
Single use, preloaded disposable syringes should be used.

Weight	**Dalteparin (Fragmin)**
Under 46 kg	7,500 units daily
46 – 56kg	10,000 units daily
57 – 68 kg	12,500 units daily
69 – 82 kg	15,000 units daily
83 kg and above	18,000 units daily
83 kg and above and at increased risk of bleeding	100 units / kg TWICE daily (maximum 18,000units/24hrs)
Pregnancy	>18/40 to be managed by Ostetrics Dosage regimen for dalteparin treatment of VTE is 100units/kg bd, maximum dose is 18,000units/24hrs. When dosing these patients, the pre-pregnancy body weight is used. Monitoring anti-Xa is only required if at extremes of body weight (discuss with a haematologist). Administer into thigh, **not**

Women of Childbearing age must have urine pregnancy test prior to starting oral anticoagulation

Warfarin Dosing Guidelines

For patients new to warfarin

Standard Regime		
BCSH Guidelines on oral anticoagulation BJH 1998 101:374		
Day	**INR**	**Warfarin dose mg**
1	**< 1.4**	**10**
2	**< 1.8**	**10**
	1.8	1
	> 1.8	0.5
3	< 2.0	10
	2.0 – 2.1	**5**
	2.2 - 2.3	4.5
	2.4 – 2.5	4
	2.6 – 2.7	3.5
	2.8 – 2.9	3
	3.0 – 3.1	2.5
	3.2 – 3.3	2
	3.4	1.5
	3.5	1
	3.6 – 4.0	0.5
	> 4.0	OMIT
4	< 1.4	10
	1.4	8
	1.5	7.5
	1.6 – 1.7	7
	1.8	6.5
	1.9	6
	2.0 – 2.1	5.5
	2.2 – 2.3	5
	2.4 – 2.6	4.5
	2.7 – 3.0	4
	3.1 - 3.5	3.5
	3.6 – 4.0	3
	4.1 – 4.5	OMIT 1 day then 2mg
	> 4.4	OMIT 2 days then 1mg

Reduced Intensity Regime

Use if one or more risk factors:

- Age>75
- Heart Failure
- Renal failure
- Weight<55kgs
- Patient on interacting medicines – see Appendix 1 of the latest British National Formulary (BNF)

Gedge et al Age and Aging 2000; 29:31-34

DAY	**INR**	**Warfarin dose mg**
1	< 1.4	**10**
2	< 1.8	**5**
	1.8 – 2.0	1
	> 2.0	OMIT
3	< 2.0	**5**
	2.0 – 2.2	4
	2.3 – 2.5	4
	2.6 – 2.9	3
	3.0 – 3.2	2
	3.3 – 3.5	1
	> 3.5	OMIT
4	< 1.4	More than 7
	1.4 – 1.5	7
	1.6 – 1.7	6
	1.8 – 1.9	5
	2.0 – 2.3	4
	2.4 – 3.0	3
	3.1 – 3.2	2
	3.3 – 3.5	1
	3.6 – 4.0	OMIT
	> 4.0	OMIT

For Both Regimes to calculate the maintenance dose:

- Continue Day 4 dose from Day 5 for 3 days
- Repeat INR on Day 8 then dose/retest according to result

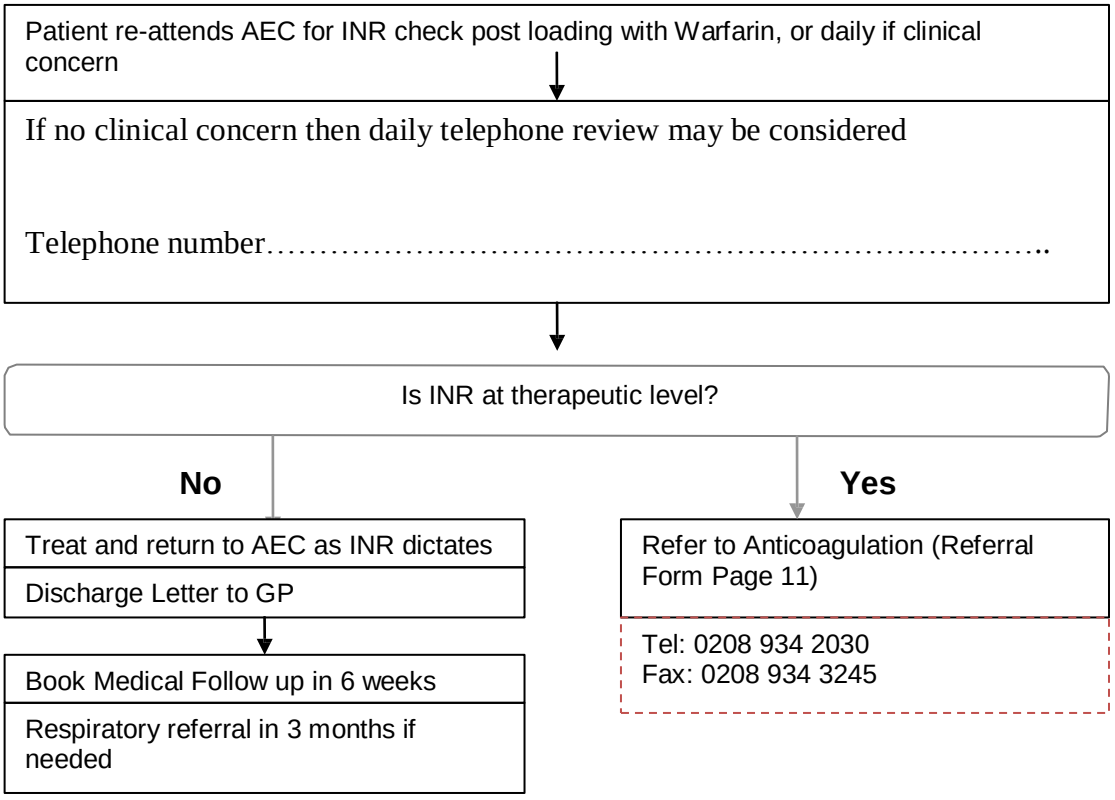
Counselling Checklist

1. Rationale for treatment		DVT/PE 3/12 / 6/12 / long term / other
2. Importance of Regular Blood tests		Appears to understand/ does not appear to understand
3. Warfarin dosing		Colours/ strengths/ dose/ time
4. Yellow Anticoagulation Therapy book		Read through with patient/ patient's representative
5. Risks/Bleeding/Bruising		Appears to understand/ does not appear to understand
6. Helpline telephone number		Identified and encouraged to use
7. Importance of informing Anticoagulation department if unwell		Appears to understand/ does not appear to understand
8. Medications/starting/stopping		Avoiding herbal medications, will inform us of changes
9. Repeat prescription info		GP to provide
10. Alcohol intake		Minimal/ None/ ____units daily
11. Diet		Diet to remain unchanged, avoid cranberry juice
12. Importance of information doctors and dentists of surgical procedures including dental work		Patient will inform us of any pending surgery or dental extractions. Also will inform doctors/dentists they are taking Warfarin
13. Sports/leisure activities		Minimal until therapeutic
14. Compression stockings		Prescription given/not given
15. Pregnancy – women of child bearing age		Counselled / N/A
16. District/practice nurse arrangements		N/A / Arranged To administer dalteparin ____units S/C OD/BD for durantion of __days commencing _____@ __:__ hrs
17. 6/52 F/U outpatient appt with medics		Arranged/Not arranged
18. Anticoagulation clinic appointment		Given _____@ __:__ hrs
19. Transport arrangements		N/A / Arranged
20. GP Letter		Sent/ Not Sent
21. Verbal Consent from patient		Yes, obtained/ No, not obtained
22. DVT/PE leaflet given		Yes/ No / N/A
23. HOSPITAL ADMISSION OR DAY CASE IN THE LAST 90 DAYS		**Yes/ No / N/A** **If yes, date, place and procedure** ****Please add to DAWN in 'events' using code HAT*****

Name …… Date…….

Signed ……....Anticoagulation CNS

PE Treatment



Presenting features	**Recommended Duration**	**Target INR**
Proximal DVT/PE	6 +months Review in Anticoagulation clinic after 6/12	2.0-3.0 (2.5)
Recurrent DVT/PE	Long Term	
Recurrent DVT/PE despite warfarin	Long Term	3.0-4.0 (3.5)

Treatment and Review Recording

Patients must have minimum of 5 days of Fragmin

Date of first anticoagulant dose: _____
Dalteparin Dose: _____units by subcutaneous injection OD/BD at _____:_____hrs (and if BD: _____:_____hrs)
Warfarin Loaded _____mgs/ _____mg/ _____mg from date: _____

When INR>2 refer to anticoagulation clinic

	Day	**Day**	**Day**	**Day**	**Day**	**Day**	**Day**
Warfarin							
Compliant							
INR							
Warfarin Dose							
Dalteparin Dose							
Clinical review required?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Comments:							

KINGSTON HOSPITAL INPATIENT FORM for the OUTPATIENT MANAGEMENT OF ANTICOAGULATION

** This form must be completed fully for an appointment to be made and the patient accepted into our care. Clinical responsibility for anticoagulation remains with the referring team until the patient is assessed in Anticoagulation clinic.**

SURNAME:	**HOSPITAL NO:**
FORENAME:	**DOB:**
HOME ADDRESS: **TELEPHONE :**	**GP: NAME & ADDRESS**
WARD:	**CONSULTANT:**
INDICATION FOR ANTICOAGULATION:	**IF ON FRAGMIN:** **Patient weight:** **Daily Dose:** **Start Date:**
IF DVT PROXIMAL CALF **SPONTANEOUS PROVOKED IF provoked what was cause:** **Long haul flight / Operation / COCP / Fracture / Injury / other** **HAT: < 90 days post hospital admission or procedure: YES / NO**	
TARGET INR:	**REASON FOR RECENT HOSPITAL ADMISSION:**

Active Cancer diagnosis: **Site:** **Chemo Tx:**

Other medical conditions (please specify):

Liver disease: Yes / No **Hypertension: Yes / No** **Peptic ulcer: Yes / No**

Alcohol intake: **Already on warfarin: Yes / No**

Family history of thrombosis: Yes / No (please specify):

OTHER DRUG THERAPY (Including recent changes for Patients already on warfarin)

PROPOSED DURATION OF ANTICOAGULATION

…… **……..**
……

Name of referring Doctor / Nurse Specialist:……. Date……

Please return completed form to the Anticoagulation Department at Kingston Hospital. *Please make transport arrangements as required for the first clinic visit.*

FAX NO: 020 8934 3245 Ext: 2041

Information for Patients

You have been asked to attend the Ambulatory Emergency Care Unit [AEC] at Kingston Hospital for continuing investigation and treatment for Pulmonary Embolism

During this admission to hospital you have been diagnosed with a possible Pulmonary Embolism (PE) this is a blood clot within your lung(s). The doctors have assessed you and have decided it is safe to send you home.

Prior to leaving the hospital you will be given:

DALTEPARIN which is administered as subcutaneous injection (into the fatty layer just below the surface of the skin in your tummy), this is to protect you from further embolic (blood clotting) events. You will require these injections once or twice daily depending on your weight.

An appointment to attend the Ambulatory Emergency Care (AEC) Unit on the next working day (the AEC is open Monday - Friday 10am – 6pm).

On the AEC one of the senior clinical staff will explain your treatment plan and commence your anticoagulation therapy (medication that makes your blood less likely to clot).

One of the anticoagulant medications that might be used is called warfarin. Warfarin needs to be closely monitored for the duration of your treatment, by doing regular blood tests. These blood tests measure your International Normalised ratio (INR), this indicates how long your blood takes to clot.

The amount of warfarin you must take will be prescribed and written inside your yellow anticoagulant therapy record book, which will be given to you by the Thrombosis Nurse Specialist.
The warfarin dose is variable and adjusted after each blood test according to the INR result.

WARFARIN will be supplied to you in 3 strengths and colours:

1mg = **BROWN** tablet
3mg = **BLUE** tablet
5mg = **PINK** tablet

*****Only ever take the dose of warfarin that has been prescribed and written up in your yellow book. Warfarin is taken at 6pm daily.*****

Once the warfarin has reached therapeutic levels, this is indicated by an INR of between 2.0 and 3.0, the dalteparin injections will be discontinued and you will be referred to Anticoagulation Clinic for your future appointments.

If you experience any abnormal or prolonged bleeding, increasing chest pain or shortness of breath, please attend the Emergency department immediately.

PULMONARY EMBOLISM A guide for patients

What is a pulmonary embolism?

A pulmonary embolism (PE) is a blood clot that has lodged inside one of the arteries in the lungs. Depending on the size of this clot, a pulmonary embolism can cause damage to lung tissue and affect the proper functioning of the damaged lung. This can be a serious condition.

Where do clots come from?

Blood clotting is a normal process. For example, if you cut yourself, eventually the blood clots and bleeding from the injured area stops. This process is necessary to ensure that damaged areas are repaired.

Occasionally though, this mechanism malfunctions and blood clots can form inside the blood vessels when the blood flow has merely slowed down or become sluggish. Clots like these generally form in the large deep veins of the leg. This is called a deep vein thrombosis (DVT). Sometimes either all or part of the DVT breaks away and travels via the circulation, passing through the heart and lodging in the lung. This is called a PE.

An embolus is a blood clot that has moved from the location where it was formed. Once it travels through the blood stream, it can obstruct a blood vessel, causing an interruption in the supply of blood.

What are the symptoms of a Pulmonary Embolism?

The symptoms of pulmonary embolism [PE] depend on a number of factors, including the location of the blockage and the size of the area affected by the lack of blood supply.
Some of the possible signs and symptoms of pulmonary embolism are:

- Feelings of being breathless that comes on suddenly with no apparent explanation.
- Pains in the chest when you breathe in.
- Feeling faint.
- Coughing up blood-stained phlegm.

How is a pulmonary embolism diagnosed?

A PE can be difficult to diagnose, as many other conditions can give rise to similar symptoms. A diagnosis of PE is made based on your symptoms, clinical examination, blood tests and lung scan.

How is a pulmonary embolism treated?

A PE is treated with anticoagulant medication. Anticoagulants are drugs that stop clots forming. At first, you will be given heparin injections. Once the diagnosis is confirmed you may be started on warfarin tablets as well. Warfarin takes a few days to start working. Once the warfarin has taken effect, the heparin injections can be stopped.

Will this anticoagulation medication break down the clot?

Neither the heparin nor the warfarin have any direct effect on the blood clot itself, your body will break that down over time.

Anticoagulants work to prevent the clot becoming any larger and moving again. They also stop new clots forming at a time when you would be at risk of this.

How long do I need to stay in hospital?

This depends on how ill you are. Some patients have mild symptoms and feel reasonably well after a PE. If this is the case then you would usually stay a few days; we are hoping to introduce a supported early discharge scheme to further reduce the hospital stay.

Other patients have large clots and can require special drugs to dissolve the clot, or are very breathless and require oxygen treatment for a few days. If this is the case, you will need to stay in hospital until you are well enough to go home.

Why did I get a pulmonary embolism?

For many patients the reasons for having a PE are unknown. Below are some factors that are known to increase the risk of blood clots forming:.

- Pregnancy/ Pregnancy / Contraceptive pill / HRT.
- Inflammatory bowel conditions.
- Previous history of blood clots.
- Advancing age.
- Immobility.
- Recent surgery especially orthopaedic or major abdominal surgery.
- Recent immobilization of leg with a plaster of Paris.
- Recent admission to hospital with an acute illness or infection.
- Cancer.
- Recent long distance travel by air, coach or car.

However, the large majority of patients sustain a PE for no identifiable reason. This is called a spontaneous or idiopathic PE.

For how long will I need anticoagulation treatment?

This decision is made on an individual basis. Generally, patients with a PE require treatment with warfarin for 12 months. This is because research has shown that stopping your warfarin before this time may increase the risk of you having another clot. For most patients there is no benefit in continuing warfarin treatment beyond 12 months.

For some patients the risk of having another PE may be assessed as being so high that treatment with warfarin is required for life. This will be discussed if this applies to you.

What is the chance of having another clot and is there anything I can do to avoid it?

Whilst you are on warfarin the chance of having another clot is remote. However, some patients will remain at risk of having another clot once treatment with warfarin is stopped. The exact individual risk is difficult to judge, but at the end of your treatment, the anticoagulant clinic you attend will discuss all the issues with you.

A few simple measures that you can take may help prevent a recurrence. If you are overweight, it is a good idea to try to reduce this. Stopping smoking is extremely important, as smoking has been linked to an increased risk of PE. Becoming fitter by gradually increasing the amount of exercise you take also helps as it improves circulation. If you are confined to a bed or a chair, regular movements like stretching are important.
Don't sit with your legs crossed or wear tight clothing below the waist.

I have heard there are some special blood tests that can tell why I had the clot.

These tests look for a range of conditions – given the general term Thrombophilia. Thrombophilia results in an individual having “sticky blood”, and therefore at an increased risk of thrombosis. Thrombophilia may either be congenital, and inherited at birth; or acquired during life. These tests are of limited benefit as they rarely alter treatment and are normally only carried out on patients who developed a blood clot for no obvious reason at a young age.

How long will the clot take to go away completely?

Again, this can differ from person to person, and can depend on your general state of health. We estimate that your body will break down the clots over a 6-12 week period. It is not necessary to repeat the scan you had.

How long will it take me to feel better?

Patients with small clots, who were previously fit and well can start to feel ‘back to normal’ in a week or two. Some patients however feel very tired, unwell, and may experience breathlessness, especially after activity, for some months. Many patients also feel quite low in mood and anxious after their PE.
Having a pulmonary embolism can be a frightening experience and it is important that you discuss these feelings with either the hospital anticoagulation clinic or your own G.P. We recommend that once at home you gradually increase the amount of exercise you take. Good exercise is brisk walking or swimming. This should be balanced with adequate sleep.

I’m going on holiday soon – Can I fly?

As soon as your warfarin levels are stable and you are medically fit to fly you can do so. However, you must ensure the following: -

- The anticoagulation clinic knows you are going away.
- You are not short of breath and will be able to cope with reduced air pressure in the cabin.
- Your insurance companies are aware that you have had a PE and are on warfarin.

REMEMBER- once your warfarin therapy has stopped you need to take precautions when travelling.
Long haul air flights and long journeys by coach or car increase the risk of clots forming in the legs. To reduce the risk of clot formation, you should take the following measures. Drink plenty of water and avoid alcohol; keep as mobile as possible [try a brief period of exercise at least every hour and even when in your seat gently exercise the legs]. Support stockings should be considered during the journey. In addition, medical advice should be sought as to whether aspirin or heparin therapy should be taken to prevent clot formation during the journey.

How soon can I go back to work?

You should not go back to work until you are physically fit enough to do so. You must discuss this with your GP first.

PREGNANCY

Warfarin taken during the early weeks of pregnancy may damage the unborn child. Therefore, if you are a female of childbearing age and taking warfarin you SHOULD NOT plan a pregnancy without consulting your doctor and anticoagulation clinic first.
If you think you may be pregnant while taking an oral anticoagulant do not delay - contact your doctor or anticoagulant clinic immediately for advice.

USEFUL WEBSITES

- www.nhsdirect.nhs.uk
- www.emedicinehealth.com
- www.patient.co.uk

Ambulatory Emergency Care Unit Information for Patients and Carers

What is Ambulatory Emergency Care?

Kingston Hospital Trust Ambulatory Emergency Care (AEC) Unit delivers a range of treatments which have historically been administered within the in-patient setting i.e. with you sitting in a hospital bed on a ward. However, evidence and experience has shown that for certain carefully selected conditions it is just as safe and the treatment is just as effective when given as an outpatient. Many people also prefer to have their treatment whilst staying in their own home.

Eligible patients receive their care in the AEC area situated on level 3 of the Surgical Unit and visit the unit on a daily basis during the course of treatment. Of course if you do require hospital admission during your treatment beds are available 24 hours a day on our associated wards.

What advantages does Ambulatory Emergency Care offer me?

You will receive the same treatment as on the ward except that it is scheduled between the hours of 10am and 6pm. This allows you to continue daily life at home.

You will continue to have 24 hours access to Medical and Nursing care despite not staying in a hospital ward. You will be given contact numbers telling you how to contact us throughout your treatment period.

Is Ambulatory Emergency Care right for me?

As you will be required to take a more active role in you care, it is important to find out whether Ambulatory Emergency Care is suitable for you. Your nurse or doctor will discuss this with you.

What can I expect?

You will be assessed and treated by an Advanced Nurse Practitioner who has extensive experience in working with patients receiving treatments in ambulatory emergency care.

The unit is open 5 days a week: Monday to Friday – 10am to 6pm. Outside of these hours you continue to have access to medical support through contacts in the Accident and Emergency department. Of course the usual ways to access medical advice e.g. NHS direct and your GP will also still be able to advise you in an emergency.

What to expect in the Ambulatory Emergency Care Unit:

- You will be seen and assessed. Your AEC nurse will take your temperature, pulse, blood pressure and weight. Blood tests and other necessary investigations will be carried out
- You will receive your prescribed treatment, any additional investigations and consequent treatment. *Treatments may sometimes run later than expected, you should allow some flexibility for this.*
- The details of the condition you are being treated for and what happens now will be given to you in writing along with contact numbers and details of any appointments.
- If you require hospital admission this will be arranged for you by the AEC nurse who will accompany you to the ward
- If you have any concerns or questions please don't hesitate to ask-we are here to help!

Your Appointments:

Date	Time	Location

If you feel unwell before your appointment please contact

- **10:00-18:00 AEC – 020 8546 7711 Page 390**
- **18:00-10:00 ED – 020 8546 7711 ext. 2178**

Kingston Hospital NHS
NHS Foundation Trust

Galsworthy Road
Kingston upon Thames
Surrey
KT2 7QB

Dear

Patient Stickers

Your patient attended the Ambulatory Emergency Care (AEC) Unit at Kingston Hospital for treatment on the PE ambulatory emergency care pathway.

A full discharge summary will be faxed to you.

Should you require urgent information please contact AEC: 0208 546 7711 blp 390

Regards,