University Hospitals Dorset
NHS Foundation Trust

# Guideline for the Diagnosis and Management of Haemodynamically Stable Pulmonary Embolus(PE)

| Approval Committee | Version | Issue Date | Review Date | Document Author(s) |
|---|---|---|---|---|
| Thrombosis Committee & D&TC | 1 | July 2019 | July 2021 | Dr Craig Prescott and Dr David Morgan |
| Thrombosis Committee & D&TC | 2 | August 2020 | August 2023 | Craig Prescott<br>David Morgan<br>Faye Thornton |

## Version Control

| Version | Date | Author | Section | Principle Amendment Changes |
|---|---|---|---|---|
| 2 | August 2020 | Faye Thornton | | Dalteparin to Enoxaparin |

## Contents

*(To Update the contents below, please right click on the dots (…) and select "Update Field > Update Entire Table > OK")*



## 1.0 Introduction

Pulmonary Embolus (PE) is a common medical emergency. These guidelines are to help in the investigation and management of PE

*The Wells score and D-dimer are helpful tools, but please remember the use of clinical judgement and senior advice is essential*

If there is clinical evidence of haemodynamic compromise please refer to guidelines on "Management of Haemodynamically Unstable Pulmonary Emboli"

## Definitions:

**Haemodynamically unstable PE** (also referred to as massive PE)
This group of patients are defined by a systolic blood pressure of less than 90 mmHg or a drop in blood pressure of ≥ 40mmHg for >15 minutes.

**Haemodynamically stable PE**
This group includes patients who are haemodynamically stable with and without evidence of heart strain.

**"Provoked"**
A PE can be provoked by transient risk factors such as a hospital admission, surgery, immobility, pregnancy, puerperium, oral contraceptive pill and hormone replacement therapy. The factors are temporary and can be reversible.

**"Unprovoked"**
This is often referred to as idiopathic PE. This is a PE in the absence of any reversible risk factor. Patients with active cancer, a family history of PE or Deep Venous Thrombosis (DVT) or a thrombophilia are included in this group as the underlying risk is likely to remain unchanged.

## 2.0 Objective / Policy Statement

The purpose of this guideline is to provide a framework for clinicians managing patients with possible and confirmed pulmonary embolus (PE). Patients may be managed in the emergency department, as an inpatient, in outpatients or Ambulatory Emergency Care (AEC).

The goal is to provide a safe and timely service for assessment, investigation and diagnosis or exclusion of PE for patients.
The guideline covers diagnosis, acute treatment, prognostication, management via AEC, follow up and investigation for thrombophilia and occult malignancy.

## 3.0 Procedures

## 3.1 Diagnosis

Assuming there is **no** evidence of haemodynamic compromise:

- Clinical history and examination, including risk factors for PE/Deep Venous Thrombosis (DVT).
- A CXR and ECG are required for all patients.
- Clinical pre-test probability scoring (2 level PE Wells score) is recommended on admission and (written in the notes) and on radiology request forms. The validated score allows objective assessment of clinical probability of PE in a patient with a history consistent with suspected PE. See below.
- Wells Scoring and d-dimer measurement for exclusion of PE is not validated in pregnancy and should not be used in patients already on anticoagulation or if symptoms have been present for more than 2 weeks (can give falsely reassuring low d-dimer results). In these cases a senior clinician should review the patient to decide on imaging.

**Clinical probability scoring: Two – level PE Wells score**

| **CRITERIA** | **SCORE** |
|---|---|
| Clinical signs and symptoms of DVT (minimum of leg swelling and pain with palpation of the deep veins) | 3 |
| An alternative diagnosis is less likely than PE | 3 |
| Pulse >100 | 1.5 |
| Surgery/Immobilisation (for more than 3 days) in the previous 4 weeks | 1.5 |
| Prior DVT or PE | 1.5 |
| Haemoptysis | 1 |
| Active malignancy (Treatment ongoing, within 6 months, or palliative) | 1 |

**Interpretation of the Wells score:**

| | |
|---|---|
| PE unlikely | 4 points or less |
| PE likely | more than 4 points |

Remember:
*The Wells score and D-dimer are helpful tools, but please remember the use of clinical judgement and senior advice is essential.*

## **If** the Wells score is greater than 4:

- Immediately commence treatment with LMWH. (If Creatinine Clearance is below 15ml/min please follow guidance of Parenteral Anticoagulation prescription chart.)
- If immediate effect is required then a STAT dose of IV Heparin 5000 units can be given (This is based on expert opinion from Haematology as Enoxaparin (Inhixa®) takes 3-5 hours to reach peak levels)
- Rivaroxaban and Apixaban can be used for immediate treatment in patients who are not haemodynamically compromised and who do not have extensive ilio-femoral DVT.
- Arrange CT Pulmonary Angiogram (CTPA).
- Ventilation/Perfusion (V/Q) scanning is available at Poole Hospital and is recommended if GFR <30ml/min or there is contrast/iodine allergy.

## **If** the Wells score is less than or equal to 4 and where there is no other cause to explain their symptoms then:

- Measure a D-dimer (negative predictive <230)
    - If D-dimer is positive treat as per Wells greater than 4 (see previous)
    - If D-dimer is negative then PE is excluded. Consider alternative diagnosis

## Results of Imaging

**CTPA**
Report likely to state PE present or not present: if there still remains doubt need to discuss individual case with radiologist. If PE not present, need to consider alternative diagnosis. If CTPA does not show a PE but a DVT is suspected then consider proximal leg vein ultrasound.

**Perfusion scan/VQ report**
Report likely to state probability of PE. Discuss the result of V/Q report with an acute physician, respiratory specialist or nuclear medicine consultant if you are unsure how to interpret the result.

## 3.2 Management of Confirmed PE and Prognostic Assessment

Ensure patients remain stable. Any patient who is haemodynamically unstable should be managed as per the haemodynamically unstable PE Guideline and senior advice should be sought.

All patients with a confirmed PE should have their prognosis assessed. This should be a combination of clinical assessment and PESI/sPESI scoring (See Figures 1 & 2 below). Any stable patient with an sPESI of 0 or PESI Class 1-2 can be deemed low risk, commenced on anticoagulation and considered for ambulatory care (See Section 3.6).

Anyone with an sPESI>1 or PESI Class 3-4 should undergo further prognostic assessment with troponin measurement and assessment of right heart strain with echocardiography or review of heart dimensions on CTPA.

Patients with one of these tests positive or both negative are deemed low intermediate risk. They should be considered for admission and commenced on oral anticoagulation.

Patients with both a positive troponin and evidence of right heart strain on echo are deemed high intermediate risk. These patients should be admitted for monitoring and commenced on LMWH as initial therapy. They can be transferred to oral anticoagulation when stable for discharge. (See Figure 3).

Figure 1 – PESI Score

**Table 3 Pulmonary Embolism Severity Index**

| Parameter | Score | Risk class | Total points |
|---|---|---|---|
| Demographic features | | I: very low | ≤65 |
| Age | Age in years | II: low | 66–85 |
| Male sex | +10 | III: intermediate | 86–105 |
| Comorbid conditions | | IV: high | 106–125 |
| Cancer | +30 | V: very high | ≥126 |
| Heart failure | +10 | | |
| Chronic lung disease | +10 | | |
| Clinical findings | | | |
| Pulse ≥ 110 bpm | +20 | | |
| Systolic blood pressure < 100 mm Hg | +30 | | |
| RR ≥ 30/min | +20 | | |
| Temperature < 36°C | +20 | | |
| Altered mental status* | +60 | | |
| Arterial blood oxygen saturation < 90%† | +20 | | |

*Defined as disorientation, lethargy, stupor or coma.
†With or without the administration of supplemental oxygen.

Figure 2 – sPESI Score

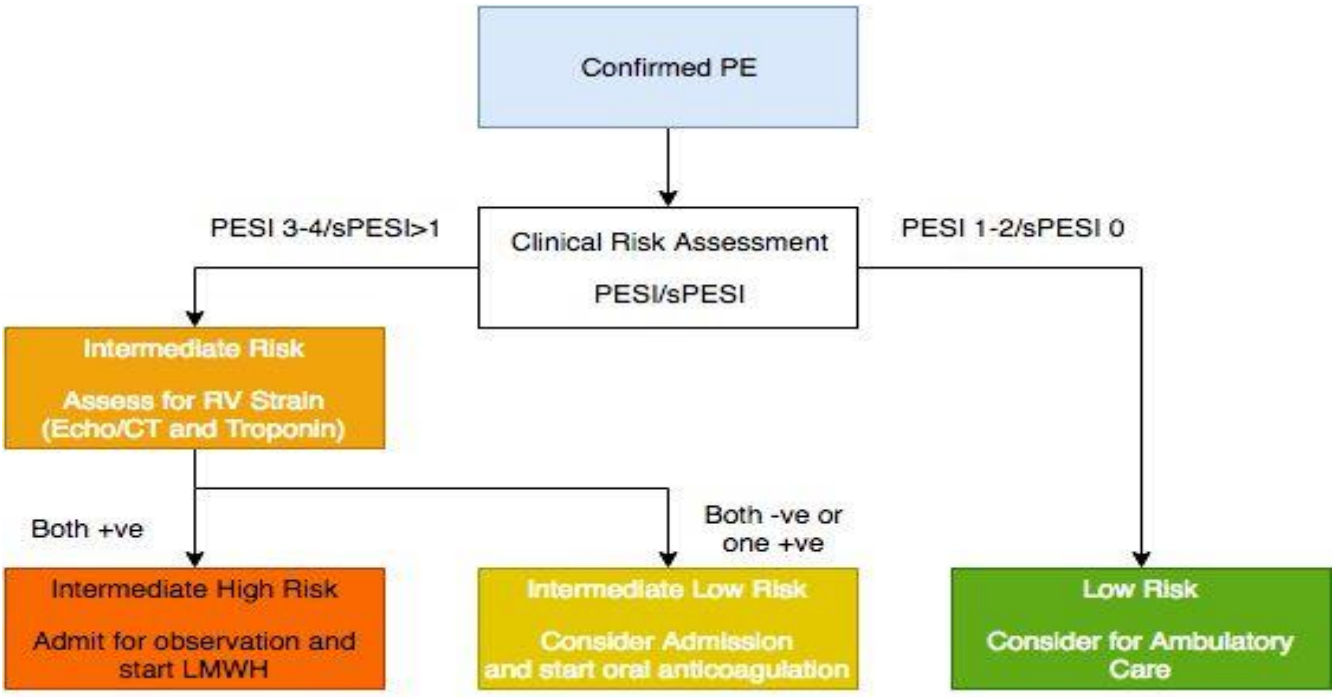
**Table 4 Simplified Pulmonary Embolism Severity Index**

| Parameter | Score | Risk class | Total points |
|---|---|---|---|
| Age >80 years | 1 | Low | 0 |
| Cancer* | 1 | High | ≥ 1 |
| Chronic cardiopulmonary disease | 1 | | |
| Pulse ≥110 bpm | 1 | | |
| Systolic blood pressure < 100 mm Hg | 1 | | |
| Arterial blood oxygen saturation < 90%† | 1 | | |

*Defined as active cancer (diagnosed within last 12 months or undergoing treatment, personal communication from Prof David Jimenez).
†With or without the administration of supplemental oxygen.

Howard LSGE, *et al*. *Thorax* 2018;**73**:ii1–ii29. doi:10.1136/thoraxjnl-2018-211539

Figure 3 – Stable PE Prognostic Assessment (Adapted from 2014 ESC Guideline on PE)



## 3.3 Anticoagulation

Patients with a confirmed PE should receive anticoagulation for **3 months**. At this point they should be reviewed and a decision made regarding indefinite anticoagulation. DOACs are the first line anticoagulation choice for treatment of PE.

In patients prognostically deemed to have high intermediate risk PE and who are initially managed as inpatients LMWH is the preferred initial treatment option. A DOAC can be used in these patients on discharge.

Please see: See Full Anticoagulation Guidelines for more details on use of Direct Oral Anticoagulants (DOAC) and vitamin K antagonists, and Heparins.

### 3.3.1 Direct Oral Anticoagulants (DOACs)

Rivaroxaban 15mg BD initial treatment 21 days prescription
To be followed by 20mg OD for 7 days (can prescribe VTE initiation pack)
GP to provide remainder of 3 month acute treatment course

Apixaban 10mg BD initial treatment 7 days prescription
To be followed by 5mg BD for 21 days
GP to provide remainder of 3 month acute treatment course

Other DOACS available
Dabigatran 150mg bd (will require 5 days LMWH prior to commencement)
Edoxaban 60mg od (will require 5 days LMWH prior to commencement)

A DOAC Check list should be completed for all patients and sent to pharmacy with all DOAC Prescriptions

** See Full Anticoagulation Guidelines and SPC for individual drugs for dose adjustments and contraindications

### 3.3.2 Warfarin

Patients should be prescribed Warfarin loading dose either 10mg or 5mg (low loading dose) for 2 days with INR check on day 3 See Full Anticoagulation Guidelines
As Warfarin may take a few days to reach a level which is effective for anticoagulation, it is important to continue the initial parenteral treatment with LMWH for at least 5 days **and** until the INR has been above 2 for two consecutive days. This is to ensure adequate anticoagulation at all times.

**Initial Prescription**
Warfarin 3mg 28 tablets and 1mg 28 tablets + 7 days of LMWH.
Patient should be counselled
Check list should be completed
An Anticoagulation Clinic referral form should be completed and an anticoagulant clinic appointment time arranged with the clinic (ext 4778 at RBH) for INR check on day 3.
Avoid warfarin in patients with history of current Intravenous misuse

### 3.3.3 Low Molecular Weight Heparin

Patients should receive therapeutic doses of LMWH until therapeutic on warfarin for 2 consecutive days. The drug of choice of LMWH is Enoxaparin (Inhixa®) See Full Anticoagulation Guidelines

## 3.4 Recurrent Venous Thromboembolism (VTE) whilst on anticoagulation

If patient has a VTE whilst on anticoagulation with warfarin ensure patient has been in therapeutic range. Consider increasing therapeutic range to INR 3.0-4.0. Ensure LMWH is given until INR>3.0.

If on a DOAC, review adherence to medication and, if rivaroxaban, ensure it has been taken with food. Consider changing to warfarin therapy with a therapeutic range INR 3.0-4.0 or LMWH. Discuss these cases with a haematologist.

## 3.5 Special Circumstances

### 3.5.1 Pregnancy (See Figure 4)

**In all pregnant patients organise a CXR and ECG as initial investigations.**

The Wells Score and D-dimer measurement is not useful in assessment of VTE in pregnancy and is not recommended.

Arrange Leg Doppler if there are signs or symptoms of a DVT and test can be performed promptly. If DVT is confirmed no further investigation is required and VTE treatment should continue.

At RBH request a CTPA for formal diagnosis of PE in pregnancy. At Poole request a Q scan as first line. If unavailable and it is deemed clinically necessary then a CTPA can be requested after review by the consultant responsible for the patient's care.

Treatment of PE in pregnancy should be with LMWH. The dose should be titrated against the woman's actual weight. Unfractionated heparin should be considered in patients at term and should be discussed with the patient's obstetrician. Vitamin K antagonists and DOACs should not be used in pregnancy. Please see: See Full Anticoagulation Guidelines

### 3.5.2 Patients already on anticoagulants

D-dimers are unreliable and best avoided for patients on all forms of anticoagulation therapy both oral and injectable.

### 3.5.3 Cancer

LMWH is first line therapy. Rivaroxaban and edoxaban can be used in patients with active malignancy, but should be avoided in patients with Gastrointestinal malignancy due to an increased risk of bleeding. Use of edoxaban or rivaroxaban in these patients should be a consultant decision. Edoxaban will require 5 days LMWH prior to commencement.

All patients with cancer should have a senior review prior to discharge.

All patients with active cancer should be referred back to their oncologist for ongoing management of their cancer and decision regarding length of anticoagulation.
Please see: See Full Anticoagulation Guidelines

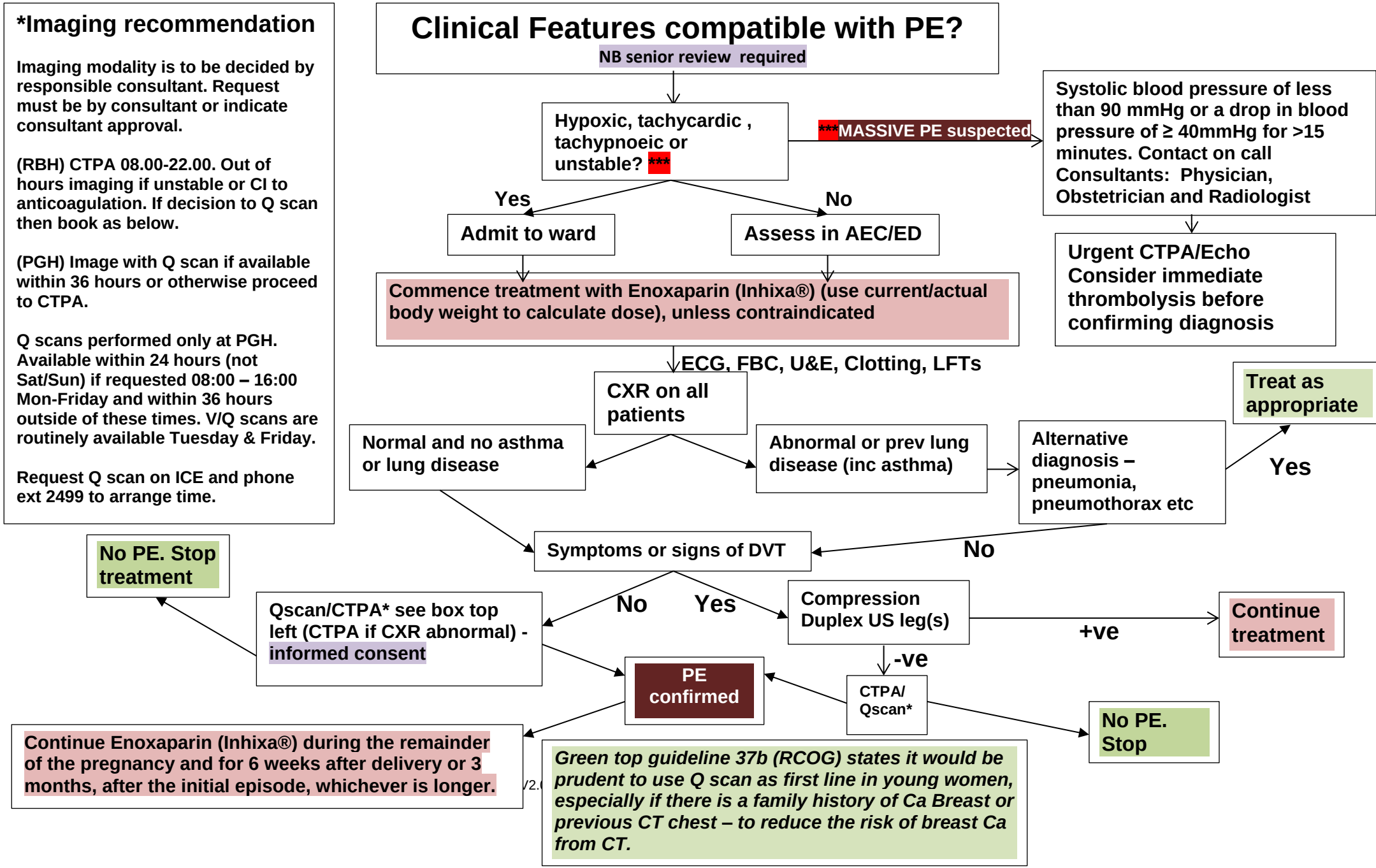
### 3.5.4 Liver and renal disease

Follow advice on Parenteral Anticoagulation Prescription chart.

### 3.5.5 Antiphospholipid Syndrome

In patients with confirmed Antiphospholipid Syndrome (APS) the treatment of choice is warfarin. DOACs should not be used.
In all patients with unprovoked PE bloods should be sent for anticardiolipin and B2 Glycoprotein antibodies. Regardless of the results DOACs can be used for the 3 month acute treatment course. This will help guide management at 3 month follow up.

## Figure 4 - Algorithm for the Investigation of Pregnant Patients with Suspected PE



## 3.6 Ambulatory Management of Confirmed PE

**We recommend clinical judgment is used in conjunction with the sPESI score. (Simplified Pulmonary embolism Severity index)**

**All patients should be reviewed by a senior clinician**

The BTS 2018 guidelines on ambulatory management of PE advice is that the PESI score or the sPESI (simplified PESI score) can be used. Patients eligible for early discharge were those with PESI score below 86 or sPESI of 0.

**Clinical Exclusion Criteria for early discharge adapted from PESI trial and BTS Guidelines**
Systolic BP< 100mmHg
Heart Rate>110 bpm
On full dose anticoagulation time of PE
Oxygen Saturations <90%
High risk of bleeding (e.g. stroke in preceding 10 days or GI bleed in preceding 14 days)
Active Bleeding
Severe chest pain needing opiates
Low platelets
Other comorbidities requiring admission
Creatinine clearance <15ml/litre
Severe liver disease
Obesity >150kg
History of Heparin induced thrombocytopenia/allergy to heparins (where there is no alternative to repeating heparin treatment)
Poor social support/risk of non-adherence e.g. alcohol or drug addictions or dementia

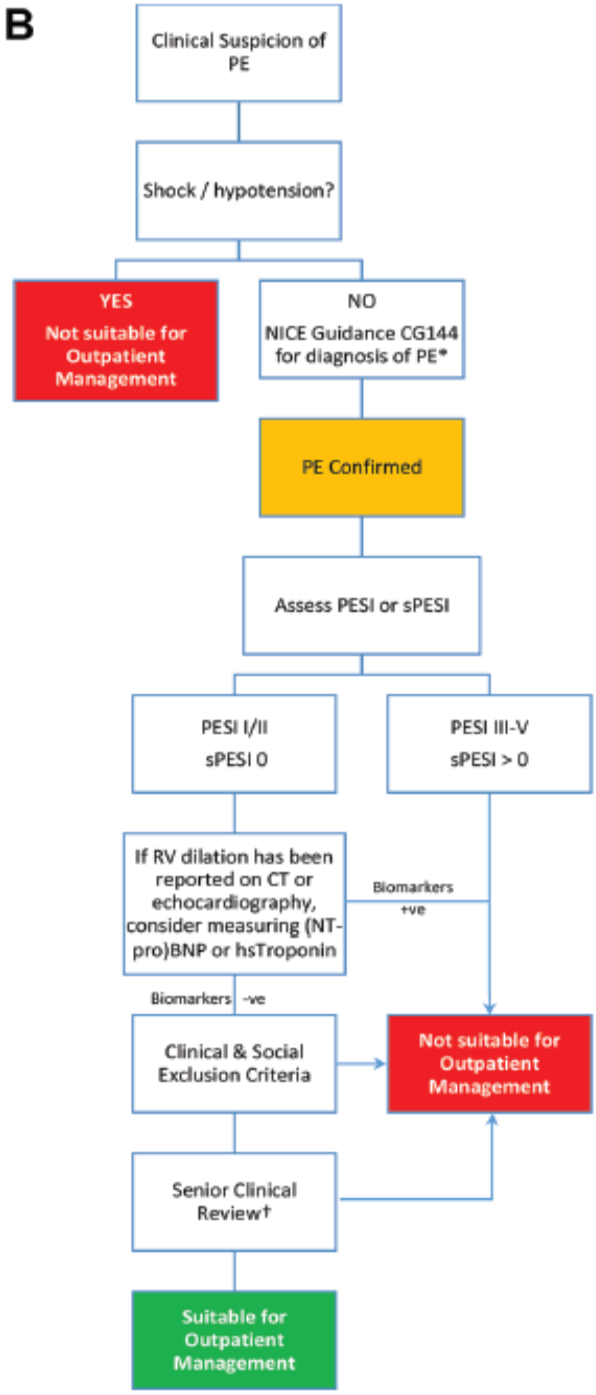
**Patient Education**
All patients with confirmed PE managed in an ambulatory setting should be provided with appropriate counselling on their diagnosis and treatment as well as information on features of recurrence and complications. They should be given an appropriate point of contact both in and out of hours. They should be provided with a patient information leaflet.

**Review**
All patients who are ambulated should have a review at 1 week to ensure adherence to treatment and absence of complications.

**Pregnancy and ambulatory management (BTS guidance July 2018)**
Good practice points

- All pregnant and postpartum women presenting with suspected PE or confirmed PE should be reviewed by a consultant and discussed with maternity services prior to discharge.
- Outpatient care pathways may be considered for suspected or confirmed PE in pregnancy and/or the postpartum period.
- Clinical risk scores derived for non-pregnant patients, such as PESI/sPESI, should not be used in pregnant women.

Figure 5 – Algorithm for assessment of suitability for ambulatory management of PE




Howard LSGE, *et al*. *Thorax* 2018;**73**:ii1–ii29. doi:10.1136/thoraxjnl-2018-211539

## 3.7 Longer Term Treatment Beyond 3 Months

**Can be with DOAC or Warfarin/Vitamin K antagonist (VKA) or LMWH -** Please see: See Full Anticoagulation Guidelines

As Warfarin may take a few days to reach a level which is effective for anticoagulation, it is important to continue the initial parenteral treatment with LMWH for at least 5 days **and** until the INR has been above 2 for two consecutive days. This is to ensure adequate anticoagulation at all times.

If a patient has **active cancer** the recommendation is to treat with LMWH for 6 months and then reassess. This is subject to shared care guidelines. Rivaroxaban and edoxaban can be used in patients with active malignancy.

If PE is **unprovoked** then NICE recommend anticoagulation is considered for longer than 3 months although the risks and benefits need careful discussion with patients especially those with a higher bleeding risk and those over 70 years.

Factors which increase the risk of recurrence after an unprovoked PE are male sex, a positive D-dimer (after stopping anticoagulation) and post thrombotic syndrome. The clot burden and severity of the PE should also be taken into account (see prognostication of confirmed PE).

If a patient has **recurrent unprovoked** PE or DVT long term anticoagulation is recommended

If a PE is **provoked** then a 3 month period of anticoagulation is recommended if provoking factor has been removed/treated.

Pregnant women should be treated with LMWH for at least the duration of their pregnancy and 6 weeks postnatally and until at least 3 months of treatment has been given.

If anticoagulation treatment is stopped, give advice about the risk of recurrence and provide:

- written information on symptoms and signs to look out for
- direct contact details of a healthcare professional or team with expertise in thrombosis who can discuss any new symptoms or signs, or other concerns
- information about out-of-hours services they can contact when their healthcare team is not available.

## 3.8 Follow Up

**All patients with PEs (except those with active cancer) should be referred for follow up in the PE clinic.**

Please refer to Dr Mainwaring (Haematology) or Dr Morgan (Respiratory) at RBH or Dr Davies (Respiratory) at Poole to review patients at 3 months to discuss continuation of treatment and to look for evidence of risk factors for chronic thromboembolic hypertension.

If a patient has active cancer please do not refer to PE clinic routinely, these patients should be managed by the Oncologist in charge of their care.

All pregnant or post-partum women diagnosed with PE should be discussed with on call consultant Obstetrician at the time of diagnosis and should be referred to their obstetrician and Dr Mainwaring for follow up.

## 3.9 Further Investigation for underlying cancer/thrombophilia

***For all patients take a thorough history including asking about weight loss and symptoms suggestive of underlying cancer. Perform a physical examination, CXR, blood tests and urine dipstick for blood. In women a breast examination is recommended and in men a prostate and testicular examination is recommended. (You may choose to do a PSA in lieu of prostate examination.)***

**CT Abdomen and Pelvis**
**It is the view of the Thrombosis Committee that a routine CT abdomen and pelvis is not indicated unless (in line with British Journal of Haematology 2015):**

**a) Bilateral DVTs**
**b) A very high D-dimer >4000**
**c) You have a clinical suspicion based on blood test results, history or examination that the patient has an underlying malignancy**
**d) Early recurrence of VTE**
**e) Recurrent VTE whilst on anticoagulation**

**Mammogram**
Please refer to the breast team if a breast mass is palpated - they will arrange appropriate investigations (e.g mammogram). A mammogram is not indicated if a mass is not felt.

**Thrombophilia screening***
**Offer** testing for Antiphospholipid antibodies (anticardiolipin and B-Glycoprotein-I antibodies) in all patients who have had unprovoked PE

**Do not** offer thrombophilia testing to patients who are continuing anticoagulation treatment.

**Do not** offer thrombophilia testing to patients who have had provoked DVT or PE.

**Do not** routinely offer thrombophilia testing to first-degree relatives of people with a history of DVT or PE and thrombophilia.

**Consider** testing for hereditary thrombophilia in patients who have had unprovoked DVT or PE and who have a first-degree relative who has had DVT or PE if it is planned to stop anticoagulation treatment.

*See also the Trust guidelines on Thrombophilia testing

**Use Unprovoked VTE Proforma (See Appendix 1)**

## 4.0 Training

Only clinicians who have undergone appropriate training will independently assess patients with possible PE. Decision regarding ambulatory care of these patients is at the discretion of a senior clinician only.

## 5.0 Process for Monitoring Compliance

Compliance with this policy will be audited as part of the medicine clinical governance processes

## 6.0 Approval, Implementation and Review

This Policy was approved by the Thrombosis Committee

## 7.0 References

NICE CG144: Venous thromboembolic diseases: the management of venous thromboembolic diseases and the role of thrombophilia testing -Jun 2012
http://www.nice.org.uk/nicemedia/pdf/ip/IPG144guidance.pdf

http://www.brit-thoracic.org.uk/c2/uploads/PulmonaryEmbolismJUN03.pdf

http://www.dorsetformulary.nhs.uk

BJH Guidelines on aspects of cancer-related venous thrombosis. 170, 640-648. Watson, H.

Screening for Occult Cancer in unprovoked Venous Thromboembolism. Carrier, M. NEJM Vol 373;8.

2014 ESC Guidelines on the diagnosis and management of acute pulmonary embolism.

NICE CKS –Pulmonary Embolism

British thoracic Society guidelines for the initial outpatient management of pulmonary embolism-July 2018

RCOG Green-top Guideline No.37b: Thromboembolic Disease in Pregnancy and the Puerperium: Acute Management – April 2015
https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-37b.pdf

## 8.0 Associated Policies

Anticoagulation Guidelines
Management of Haemodynamically Unstable PE

## 9.0 Consultation

| Version | Date | Authors | Consultation Process |
|---|---|---|---|
| 1.0 | June 2019 | Dr Craig Prescott, Consultant Acute Physician (PGH) and Dr David Morgan, Consultant Respiratory Physician (RBH) | Acute Physicians PGH &RBH<br>Dr Jason Mainwaring, Consultant Haematologist (RBH)<br>Dr Chris Davies, Consultant Respiratory Physician (PGH)<br>Dr JP Carpenter, Consultant Cardiologist (PGH)<br>Mr Rob Sawdy, Consultant Obstetrician (PGH)<br>Dr Nicky Robson, Consultant Radiologist (PGH)<br>Dr Russell Bull, Consultant Radiologist (RBH)<br>Hayley Flavell, Anticoagulation Nurse Consultant (RBH)<br>Wendy Etrata, Advanced Nurse Practitioner in Acute Medicine (PGH) |

Appendix 1

# Unprovoked VTE Proforma

Version 3 (6/2019)

Name –

Hospital No –

DOB -

**Diagnosis -** Proximal DVT □ PE □

**Treatment -** DOAC □ LMWH □ Warfarin □ Other □ ……..

**Duration -** 3/12 □ Indefinite □ Other □ ……..

**Risk Factors -** Active Cancer □ Recent Surgery □ Immobility □ None □

**History**

**Examination**

**CXR**

**Bloods (FBC, LFTs, Ca, PSA)**

**Urinalysis**
(If blood >2+ send for cytology)

**CT abdo/pelvis** - >40 years old **and** evidence of malignancy, ddimer >4000, bilateral proximal DVT, phlegmasia cerulea dolens or recurrent VTE on anticoagulation

Requested □

**Mammogram** - Females > 40 should be referred to the breast team if they have evidence of metastatic disease with unknown primary on other investigation, previous breast cancer without mammography in past 6 months or clinical evidence of breast cancer.

Requested □

**Thrombophilia Testing** –
**Offer Antiphospholipid Antibodies testing for all unprovoked VTE (Anticardiolipin and B-Glycoprotein-I Antibodies)**

Requested □

Do not perform any other thrombophilia testing at diagnosis. This can be considered at follow up.

Plan –

Refer for 3/12 Follow Up □

Name –

Position/Bleep –

Signature –

**EQUALITY IMPACT ASSESSMENT – SCREENING FORM**

| | |
|---|---|
| **1. Title of document/service for assessment** | Guideline for the Diagnosis and Management of Haemodynamically Stable Pulmonary Embolus(PE) |
| **2. Date of assessment** | August 2020 |
| **3. Date for review** | August 2023 |
| **4. Directorate/Service** | |
| **5. Approval Committee** | D&TC |

| | **Yes/No** | **Rationale** |
|---|---|---|
| **6. Does the document/service affect one group less or more favourably than another on the basis of:** **N.B. The 'Rationale' box must be completed whether the answer is Yes or No.** | | |
| • Race | No | |
| • Gender (including transgender) | No | |
| • Religion or belief | No | |
| • Sexual orientation, to include heterosexual, lesbian, gay and bisexual people | No | |
| • Age | No | |
| • Disability – learning disabilities, physical disabilities, sensory impairment and mental health issues | No | |
| • Marriage and Civil Partnership | No | |
| • Pregnancy and Maternity | No | |
| **7.** Does this document affect an individual's human rights? | No | |
| **8. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?** | No | |

| **9. If the answers to any of the above questions is 'yes' then:** | **Tick** | **Rationale** |
|---|---|---|
| Demonstrate that such a disadvantage or advantage can be justified or is valid | | |
| Adjust the policy to remove disadvantage identified or better promote equality | | |
| If neither of the above possible, submit to Diversity Committee for review. | | |

**10.** Screener(s)

Print name……

| | |
|---|---|
| **11.** Date Policy approved by Committee | |

**12.** Upon completion of the screening and approval by Committee, this document should be uploaded to papertrail.