

## Guidelines for Most Appropriate Service For Clinical Consultation & Admissions From Emergency Department

GRH and SMGH have developed a referral guideline to ensure that patients with identified diagnoses or presenting problems in the Emergency Department are referred to the most appropriate Service. The guideline is meant to recognize the areas of expertise of each of the Services, but is not meant as a substitute for clinical judgement. Individual circumstances may alter consultation choice.

This guideline encompasses only those diagnoses in which expertise may overlap, and where subsequent disposition may otherwise be unclear.

The guideline for referral follows certain general principles:

1. If the pathology or chief complaint is related to a specific subspecialty then the referral goes to that subspecialty. These guidelines identify the subspecialty by diagnosis.
2. Patients discharged from a service within the last 14 days should be readmitted under the previous service, excluding new acute illness that requires alternative subspecialty management (eg. MI, stroke, new acute appendicitis or fracture)
3. If there is a dual diagnosis – in other words two subspecialties can be involved – it is the decision of the referring ER physician as to which is the key problem and which would direct the referral.
4. If there is a dispute between two or more Services regarding which is to admit a patient for ongoing investigation and/or care, the Dispute Resolution Process (attached) should be followed.
5. In the guideline below, the term “Medicine Bed” is meant to refer to a general medicine admission – that is, both the hospitalist service and the CTU service, depending upon the location of the available bed.

Diagnosis/Clinical Presentation	Description	Service
<b>CNS</b>		
Ischemic/Embolic Stroke	Potential candidate for tPa	Stroke Protocol Team/ICU
	Not a candidate for tPa, and unstable or requires ventilation	Intensivist
	Brainstem/Large cerebellar/Bilateral cerebellar	ICU/Neurology consult; Consider tertiary care referral
	Atypical / Young age	Stroke Bed (Hospitalist/Neurology or GIM consult)
	All other ischemic strokes, presenting to either GRH SMGH	Stroke Bed GRH (Hospitalist)
	Imminently Palliative	Hospitalist
TIA	High Risk	Stroke Bed (Hospitalist)
	Low Risk	Discharge with Referral SSPC
Intracranial Haemorrhage	Cerebellar, subdural/epidural/subarachnoid/any potentially surgical	Tertiary Neurosurgery
	Inoperable/unstable/ventilated	ICU
	Inoperable/palliative/other	Stroke bed (Hospitalist)
Closed Head Injury	Abnormal CT scan/GCS < 15	Neurosurgery
	Normal CT scan/GCS 13-15	ICU or Medicine Bed
	Normal CT scan / GCS 15/stable	Medicine Bed
Seizures	Status Epilepticus, CT +ve	Neurosurgery
	Status Epilepticus, CT -ve	ICU
	Transferring from ICU, high potential for unstable	Medicine B
	Others	Medicine Bed
Miscellaneous CNS	New onset s/s, rapidly progressive, close observation	ICU B + neurologist
	Guillaine Barre, new or subacute	ICU/Consider tertiary consult

	Guillaine Barre, chronic or repatriation	Medicine Bed
	Meningitis	ICU or Medicine Bed
<b>CARDIOVASCULAR</b>		
Suspected Primary Cardiac Problem	Regularly follows with Cardiologist or CHF or cardiac inpatient recently	Cardiology
Syncope	Documented Ventricular arrhythmia or cardiac patient	Cardiology
	Suspicious for arrhythmia	CTU for monitor bed
	Others	Medicine Bed
Arrhythmias	Requiring telemetry, hemodynamically stable	Cardiology (SMGH); CTU (GRH)
Atrial Fibrillation	Uncontrolled, hemodynamically unstable	Cardiology
	With ischemia or significant CHF	Cardiology (SMGH); ICU B (GRH)
	Responding to initial ER treatment, hemodynamically stable	Medicine Bed
Chest Pain or suspected Acute Coronary Syndrome	Adult with congenital cardiac abnormality	Cardiologist
	ACS with ST elevation/dynamic or new ECG changes/hemodynamic instability	Code STEMI - Cardiologist
	ACS with NSTEMI/cTn elevation/hemodynamic instability	Cardiologist
	ACS with NSTEMI, candidate for invasive intervention	Cardiologist
	ACS with NSTEMI, not a candidate for invasive investigation	ICU or CTU depending upon stability
	ACS, palliative	Medicine Bed
CHF	Intubated	ICU
	Associated with ischemia, complex rhythm disturbance/hemodynamics unstable	Cardiology (SMGH); ICU (GRH) or CTU where monitored bed is required
	Others	Medicine Bed
Hypertensive Crisis	Requiring IV antihypertensives	ICU
	All others	Medicine Bed

RESPIRATORY		
Suspected primary lung disease	Under regular care by respirologist or recent inpatient under respirology service < 30 days	Respirology
CAP	Unstable gas exchange, high O2 requirements	Respirology(SMGH) or ICU+ Respirology consult (GRH)
	Stable gas exchange, low O2 requirements	Medicine Bed
COPD/Asthma	Requiring ventilation or BiPap	ICU / Respirology consult
	Unstable gas exchange	Respirologist (SMGH) or ICU + Respirology (GRH)
	Frequent hospitalizations/Severe but not requiring ICU	Respirologist (SMGH) or Medicine Bed + Respirology consult (GRH)
	All others	Medicine Bed
Pulmonary Embolism	Hemodynamically significant; clot in transit; unstable gas exchange/ high O2 requirements; co-existing coagulopathy	Respirology
	All others	Medicine Bed
Abnormal CXR	Cavitating lesions; masses suspicious for Ca and requiring bronchoscopy	Respirologist
	Pleural effusions with fever or systemic symptoms/locuated fluid collections	Respirology (SMGH) or Medicine + Acute Respirology consult (GRH)
	Pneumothorax	Respirology (SMGH) or Surgery
Hemoptysis		Respirology
GASTROENTEROLGY		
GI Bleed	Hemodynamically unstable	ICU + GI consult
	Hemodynamically stable	GI
	Hemodynamically stable, GI bleed minor component of presentation	GI
Bowel Obstruction	Primary Oncology Dx + palliative approach only	Oncology (not imminently palliative, Surgery consult)
	All others, including non-operative and obstruction with IBD	General Surgery with GI consult where underlying IBD

Diverticulitis	All	General Surgery
Pancreatitis	Biliary(supported by history, MI and/or elevated LFTs)	General Surgery
	Non-biliary, moderate	GI
	Non-biliary, mild	Medicine bed
Inflammatory Bowel Disease	New or flareup/already follows with local GI	GI
	Nutritional support required	GI
	With suspected obstruction or abcess	General Surgery + GI consult
Biliary Tract Disease	Biliary colic; ascending cholangitis; obstructive jaundice	General surgery
	Non-obstructive jaundice	GI
Ischemic Colitis		General Surgery
Cirrhosis	New Dx, cause unknown; previous dx followed in community or recent inpatient with GI	GI
	Chronic, stable, palliative	Medicine Bed
Undifferentiated Abdominal Pain or Unexplained Weight Loss	Fever, leukocytosis, abdominal guarding	General Surgery
	Requires Surgery reassessment or monitoring for potential need for surgery	General Surgery
	Suspected primary alimentary tract disease, facilitation of early endoscopic workup is required	GI
	Recent inpatient admission under GI within 30 days or regularly follows in community with GI	GI
	Suspected Gyn cause	GYN
	Suspected renal calculus	Urology
	All others	Medicine Bed
Hepatitis / Liver Failure	Acute; Chronic already followed by GI or inpatient under GI <30 days	GI
	Chronic, stable or palliative	Medicine Bed
	Suspected SBP	GI
<b>UROLOGY</b>		
Urinary Retention	Acute, as only presenting complaint	Urology
Stent issues		Urology

Pyelonephritis	Obstructing ureteric stone or GU procedure within 14 days	Urology
	Hemodynamically unstable	ICU
	All others	Medicine Bed
<b>RENAL</b>		
Renal Transplant patients	Admitted for any reason	Notify Nephrology
All Dialysis patients	Admitted for any reason	Courtesy call to Nephrology
Acute Renal Failure	Obstructive, requiring percutaneous or surgical intervention	Urology
	New onset, requiring urgent dialysis for fluid overload, electrolyte disturbance or overdose OR glomerulonephritis/renal specific disease likely	Nephrology- SMGH patients prefer transfer to GRH bed if available
	New onset, dialysis unlikely required	Medicine Bed
	ICU/ACOU transfers to floor with ongoing primary renal issues requiring significant daily nephrology decision-making	Nephrology
	ICU/ACOU Medicine transfers where nephrology issue is largely resolved	Medicine Bed
Chronic Renal Failure	Known to nephrology, primary problem with fluid overload, electrolyte disturbance, overdose	Nephrology
	Known to nephrologist, requires creation or revision of access	Nephrology
	Known to nephrologist, with infection/sepsis likely related to indwelling line, peritonitis (PD patients), abdominal pain with possible PD peritonitis, and thrombosis of access or other complication of treatment	Nephrology
	Known to nephrologist, sent to ER from dialysis with non-cardiac/likely dialysis related hypotension	Nephrology
<b>ENDOCRINOLOGY</b>		
Diabetes	DKA with acidosis or electrolyte imbalance	ICU + Endocrinologist
	Mild DKA or HONKS requiring IV insulin infusion but not ICU	CTU + Endocrinologist
	Improving/resolving DKA, stable, no longer requiring IV insulin infusion	Medicine Bed
	Non-DKA hyperglycemia	Medicine Bed
	New Type 1 Diabetics	Medicine Bed +

		Endocrinologist
	Hypoglycaemia, protracted or clinically unstable	ICU
	Hypoglycemia, stable, responding	Medicine Bed
Addison's Crisis	Unstable	ICU + Endocrinologist
	Stable, chronic	Medicine Bed
	New onset, stable	Medicine Bed + Endocrinologist
<b>INFECTIOUS DISEASE</b>		
Sepsis	With shock (hypotension, oliguria, thrombocytopenia, impaired LOC)	ICU
	Without shock but high risk potentially unstable	CTU
	Hemodynamically stable; localized infection without shock	Medicine Bed
Cellulitis	Suspicious of necrotizing fasciitis: Upper Limb/hand	ICU+ Plastics
	Lower Limb	ICU + Orthopedics
	Trunk	ICU + General Surgery
	Perineum male	ICU + Urology
	Perineum female	ICU + Gynaecology
	Face	ICU + Plastics
	Face and Orbit	ICU + Plastics + Ophthalmology
	Oropharyngeal/laryngeal/neck	ICU + ENT
	Diabetic foot infection, non-salvagable	Orthopedic Surgery + GIM consult
	Diabetic foot infection, possibly salvagable	Medicine Bed + Ortho consult
	Other	Medicine Bed
Spinal Infections (including discitis and osteomyelitis)	Septic, unstable	ICU
	Neurological deficits or spinal cord compression; abcess or hematoma on imaging	Spinal Surgery or Neurosurgery
	Previous spinal surgery at site of infection or actively seen by orthopaedics or neurosurgery within 12 months	Spine surgery or Neurosurgery
<b>MISCELLANEOUS MEDICAL</b>		
Repatriation	For general medical issues	Medical Bed

Pregnant with Primary Medical Problem on Presentation	All	CTU
Others	Complex; drug overdose not requiring ICU but significant complications possible and requires monitor	CTU
	High risk potentially unstable	CTU
	Stable, uncomplicated	Medicine Bed
Oncology Patients	Febrile neutropenia	Oncologist
	Primary medical issue unrelated to oncology dx which is not currently actively treated	Medicine Bed
	Palliative Care	Medicine + PSM Consult
<b>VASCULAR PROBLEMS</b>		
Thoracic Aortic Dissection	Type A (proximal to left subclavian artery)	Cardiovascular Surgery
	Type B (distal to left subclavian artery)	Intensivist
Abdominal Aortic Aneurysm		Vascular Surgery
Ischemic Limb, Acute		Vascular Surgery
Ischemic Limb/PVD subacute or Chronic		Vascular Surgery
Ischemic/Gangrenous Limb Requiring Amputation		Orthopedic Surgery
<b>TRAUMA</b>		
Trauma	Hemodynamic instability	Intensivist
Polytrauma	Not requiring tertiary transfer	General Surgery + All appropriate services
Single system injury or for observation with a history of high impact or significant mechanism of injury		General Surgery or most appropriate service
Minor injuries resulting from low impact or no significant mechanism of injury	Suspected soft tissue injuries only, requiring admission for analgesia or mobility	Medicine Bed
Chest	Pneumothorax	General Surgery +/- Respiriology
	Rib Fractures or minor chest wall injuries in high risk patients (COPD, elderly)	Intensivist B or Respiriology
	Other minor chest wall injuries	Medicine Bed

Facial Fractures	Nasal fractures	ENT	
	Other facial fractures	Plastics	
	Orbital blowout fractures	Ophthalmology vs Plastics	
Dental Trauma		Oral Surgery	
Orthopedic Injuries	Extremity fracture requiring surgical consult for assessment or intervention	Orthopedic Surgery	
	Pelvic fracture, unstable or open book	Orthopedic Surgery	
	Pelvic fracture of pubic ramus, stable	Medicine Bed	
	Vertebral fracture, cervical	Spine Surgery or Neurosurgery	
	Vertebral fracture, thoracolumbar	Spine Surgery or Neurosurgery	
	Vertebral osteoporotic compression fracture with neurological sequelae	Spine surgery or Neurosurgery	
	Vertebral osteoporotic compression fracture without neurological sequelae	Medicine bed	
	Spinal Injury awaiting next day transfer to tertiary center	ICU	
Back Pain/Acute Inability to Ambulate	With neurological signs/symptoms of cord compression or acute disc herniation	Spine Surgery or Neurosurgery	
	Chronic disc herniation with nerve root compression signs/symptoms	Outpatient back to family MD with specialist referral as required	
	Acute Mechanical back pain with no neurological signs or symptoms of cord compression or herniated disc excluded above	Medicine Bed	
	Chronic mechanical back pain with no neurological signs/symptoms	Outpatient, back to family MD	
	Primary muscle weakness or other acute neurological problem NYD	Medicine bed + Neurology consult	
	Other stable non-neurological and non-neurosurgical MSK illness	Medicine Bed	
ENT			
Epistaxis	No underlying pathology	ENT	
	Blood disorder including anticoagulation	ENT + CTU	
Throat infections	Tonsillitis – simple, pediatric	Pediatrics + ENT consult	
	Tonsillitis – no airway issue, admission for pain or rehydration	Medicine + ENT consult	
	Pharyngeal/retropharyngeal abscess	ENT	
	Dental abscess without airway issue	Oral surgery or dentistry	

