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| --- | --- | --- |
| **fPrimary Concern** | **Reason for Admission** | **Designation Team**  **(in order of preference)** |
| Cardiac | Potentially Cardiac Related problems LOC medical-surgical telemetry  ACS/Heart Failure (LVH or RVH)/New or unstable arrythmia/cardiogenic syncope/Hypertensive urgency or emergency with above cardiac complication/Cardiac arrest | Cardiology/CCU |
| Cardiac | Aortic dissection/Cardiac Mass/Valve related acute decompensated heart failure | CT Surgery Determined, CT Pod vs CT telemetry, vs CVICU under Cardiac Surgery |
| Cardiac | Heart transplant patient with primary reason for admission being cardiac. | Transfer to transplant center if regional. Otherwise, Heart Team  If non cardiac reason for admit then admit to medicine. |
| Cardiac/  Pulmonary | Patients with both heart failure and renal failure, patients with both heart failure and COPD, or patient with heart failure, renal failure, and COPD | ED determined (ED attending to decide)  If Outside ED can be transferred to ED to ED to determine ultimate dispo |
| CNS | Acute Stroke, TIA requiring IV gtt anti-hypertensives | ICU |
| CNS | Acute Stroke, TIA without hypertension | Stroke Service-ASU |
| CNS | Acute Stroke, TIA with LVO | ICU |
| CNS | Acute, nontraumatic intracerebral hemorrhage | ICU/ASU see ICU criteria |
| CNS | Acute, repetitive seizures in the absence of an underlying toxic, metabolic, or infectious etiology | Epilepsy/Neurology |
| CNS | ALS with decompensation or dyspnea | ICU/Neurology Consult |
| CNS | ALS without decompensation | Neurology |
| CNS | Concern with DBS (deep brain stimulation) | Neurology |
| CNS | Critically ill patients with primary neurologic condition that need further stabilization or diagnostic procedures | ICU |
| CNS | DBS system disruption or infection | Neuro-Surgery |
| CNS | DVT/PE in patient with known brain tumor | Internal Medicine |
| CNS | EEG-Proven non-convulsive status epilepticus | Epilepsy/Neurology vs ICU |
| CNS | Hydrocephalus without VPS obstruction | Neurology |
| CNS | Hydrocephalus with VPS obstruction | Neurosurgery/see ICU criteria |
| CNS | Intracerebral Hematoma (Hypertensive stroke) | Stroke Service-ASU |
| CNS | Limited (non-operative) SDH | Trauma |
| CNS | Massive stroke or CNS bleed deemed non-survivable | Neurology or Neurology-ASU depending on neuro check requirements vs. ICU depending on critical care and palliative statuses |
| CNS | Multiple Sclerosis acute exacerbation | Neurology |
| CNS | Myasthenia gravis crisis | Neurology/ICU see ICU criteria |
| CNS | New brain tumor/mass  Worsening neurological symptoms from known brain tumor/mass | Neurosurgery first call if decline then Medicine |
| CNS | Brain Abscess | Internal Medicine/ICU see ICU criteria |
| CNS | Non-Traumatic SAH (even if CTA normal) | Neurosurgery |
| CNS | Seizures of known origin needing EMU and/or medication adjustment | Epilepsy/Neurology |
| CNS | Seizures of Unknown Origin | Epilepsy/Neurology |
| CNS | Status Epilepticus | ICU |
| CNS | Periodic paralysis with acute weakness | Neurology |
| CNS | Pituitary adenoma?? | Neurosurgery/ENT |
| CNS | Pituitary apoplexy (with visual changes) | Neurosurgery |
| CNS | Possible acute Guillain Barre | Neurology vs ICU depending on severity |
| CNS | Traumatic Brain Injury (Any) | Trauma |
| CNS | VP Shunt with Fever | Neurosurgery with (+) tap, otherwise Internal Medicine |
| Colon and Rectal | Crohn’s Flare | Internal Medicine |
| Colon and Rectal | IBS/Abdominal pain NOS | Internal Medicine |
| Colon and Rectal | Rectal Prolapse | Colorectal surgery |
| Colon and Rectal | See Below under “Surgical” for SBO | See below for “Surgical” for SBO |
| Colon and Rectal | Ulcerative Colitis | Internal Medicine |
| Colon and Rectal | Need for Colon or Rectal Surgery?  Acute mesenteric ischemia/SBO/Large bowl obstruction/ruptured appendicitis/complicated or ruptured diverticulitis | General surgery/Acute Care Surgery |
| Derm | Concern for SJS/TEN/Acute Extensive Burns (30% Body surface area or greater) | Derm consult Send to Hospital with Burn Unit (WHC) |
| Derm | Other dermatological issue | ED to ED to assess above otherwise Internal Medicine |
| Dental | Dental trauma (teeth fracture, alveolar ridge fracture), dental abscesses | Transfer to facility with dentistry (WHC, Howard) |
| ENT | Head and neck cancer requiring surgical intervention, tracheomalacia, tracheal stenosis, tracheostomy issue requiring surgical intervention in medically non-complex patient | ENT |
| ENT | Odontogenic or non-odontogenic abscess (even if drained in ED) requiring inpatient ABX | Internal Medicine |
| ENT | Non-surgical ENT infections requiring inpatient antibiotics (tonsillitis, otitis media, mastoiditis, parotitis, osteomyelitis, sialadenitis, retropharyngeal abscess, peritonsillar abscess) | Internal Medicine |
| ENT | Epistaxis following a postoperative procedure performed by GW ENT | ENT |
| ENT | Epistaxis secondary to medical comorbidities (e.g. HTN, hereditary telangiectasia, leukemia, or other hematologic or cardiovascular etiologies) | Internal Medicine |
| ENT | Epistaxis controlled with packing by the ED or an outside facility and transferred for observation | Internal Medicine |
| Endocrinology | Any Admission/Transfer requiring inpatient endocrinology (eg. Hypothyroidism/Hyperthyroidism, adrenal insufficiency/crisis | Internal Medicine |
| General | General medicine issue, or patients not requiring specialty care with general complaint or multiple medical issues to manage. | Internal Medicine |
| GI Bleed | Unstable and/or critical GI bleed | ICU |
| GI Bleed | HD stable GI bleed | Internal Medicine |
| GI | Abdominal or pelvic Solid Organ abscesses (ie liver, kidney, spleen etc.) | Internal medicine |
| GI | Abdominal or pelvic Cavity Abscess | Surgery |
| GI | Acute/chronic pancreatitis (without gallstones) | Internal Medicine |
| GI | Gallstone pancreatitis | Surgery |
| GI | Acute Cholecystitis (acalculous cholecystitis admit to medicine) | Surgery |
| GI | Choledocholithiasis | Surgery |
| GI | Esophageal Stricture/Stenosis | Internal Medicine |
| GI | Pancreatic pseudocysts, stable needing IR drainage | Internal Medicine |
| GI | Pancreatic Pseudocysts with obstruction, bleeding, peritonitis | ICU |
| GI | Complications of/decompensated cirrhosis, critical care | ICU |
| GI | Complications of/decompensated cirrhosis, stable | Internal Medicine |
| GYN | GYN surgery(menorrhagia/abnormal uterine bleeding/PID/vaginitis/cervicitis/endometritis) | GYN |
| GYN | GYN-Onc related issue | GYN-ONC |
| GYN | Postpartum complication within 6 weeks of birth including: hemorrhage, cardiomyopathy, sepsis and severe hypertension | OB |
| GYN | Vaginal Bleeding | GYN |
| Hand | Surgical/Non-surgical hand infection with or without trauma and w/o other acute medical issues | Ortho-Hand |
| Hyperbaric | Any Hyperbaric need | Transfer out |
| Interventional Radiology | Any Interventional Radiology admission | Internal Medicine vs ICU |
| Liver | Acute Liver failure | ICU |
| Medicine/  Cardiology | Indeterminate troponin levels in patients with another issue or multiple other acute medical issues (eg. Renal failure/sepsis) | Internal Medicine |
| OB | HELLP Syndrome | OB |
| OB | Eclampsia | OB |
| OB | Pre-eclampsia | OB |
| OB | Pre-partem and Term Laboring patients | OB |
| OB | Pregnant patient with medical/surgical problem | Joint discussion between on call OB and IM/Surgery attending |
| OB | Unstable Gestational Diabetes (not critical) | OB |
| Oncology | Newly diagnosed neoplasms without established tissue diagnosis (excludes any concern for Leukemia/lymphoma see below) | Internal Medicine |
| Oncology | Leukemia/Lymphoma or concern for leukemia/lymphoma | DO NOT ACCEPT (Exceptions for established MFA patients or ED Admits) |
| Oncology | Hematologic Emergency (Tumor Lysis Syndrome/Blast Crisis) | DO NOT ACCEPT (exceptions made for established MFA patients or ED Admits) |
| Oncology | Oncology patients followed by non-GWUH oncologists cases by case bases based on above diagnosis (eg excludes leukemia/lymphoma) | Internal Medicine |
| Oncology | Oncology patients followed by GWUH/Initiation or continuation of chemotherapy in house | Internal Medicine |
| Ophthalmology | Isolated ocular infections/issues requiring inpatient acute care | Internal Medicine |
| Ophthalmology | Traumatic ocular injury | Trauma |
| Ortho | Septic joints in patients without other acute medical issues (e.g., AKI, poorly controlled DM/HTN, electrolyte abnormalities etc.) | Ortho-General |
| Ortho | Isolated extremity fractures in a medically non-complex patient with no indication of internal organ injury not isolated to hand or spine | Trauma |
| Ortho | Isolated Hip Fracture in patient who is 65 >/= or medically complex (e.g., AKI, poorly controlled DM/HTN, electrolyte abnormalities etc.) | Medicine |
| Ortho | Isolated spinal fractures in a medically non-complex patient with no indication of internal organ injury | Trauma |
| Ortho | Fractures with no indication of internal organ injury needing admission for pain control in patient without active medical issues (e.g., AKI, poorly controlled DM/HTN, electrolyte abnormalities etc.) | Ortho |
| Ortho | More than 1 fracture (any location) | Trauma |
| Podiatry | Podiatric complications/issues requiring inpatient care | Internal Medicine |
| Postop, NEW medical issue after surgical discharge (non-Ortho, non-Trauma) | New (but related) medical complications such as DVT/PE, SBO r/t pain medications or surgery, or PNA, etc. following surgery | Back to Surgical Service who performed the surgery unless >30days post-op, then Internal Medicine |
| Postop, NEW medical issue after surgical discharge (TRAUMA) | New (but related) medical complications such as DVT/PE, SBO r/t pain medications or surgery, or PNA, etc. | Back to Trauma if within 30 days of discharge |
| Pulmonary | Pulmonary artery HTN or Pulmonary HTN on intravenous infusions or requiring Swanz Ganz catheter or hemodynamic monitoring or other critical care need | CCU/ICU 2 or Heart Team 3 South |
| Psychiatry | Imminent threat to self or others requiring 24 hour professional observation and care including cases where the patients symptoms such as command hallucinations directing harm to self or others where there is the risk of the patient imminently acting on them | Psychiatry |
| Psychiatry | Active symptoms of mood, anxiety, or posttraumatic disorder which presents as an imminent danger to self or others | Psychiatry |
| Psychiatry | Complex psychiatric medication tapers or titrations that cannot be conducted safely as an outpatient | Psychiatry |
| Psychiatry | Failure of outpatient psychiatric treatment so that the beneficiary requires 24-hour professional observation and care | Psychiatry |
| Psychiatry | Acute disordered/bizarre behavior or psychomotor agitation or retardation that interferes with the activities of daily living (ADLs) | Psychiatry |
| Psychiatry | Cognitive impairment (disorientation or memory loss) due to an acute psychiatric disorder (other than neurocognitive disorder/dementia) that endangers the welfare of the patient or others | Psychiatry |
| Psychiatry | Psychiatric patient who cannot perform basic ADL’s | Internal Medicine (with Psych C/L team following) |
| Psychiatry | Patient in active withdrawal needing telemetry monitoring or a history of complex withdrawal (e.g. seizures, DT’s) | ICU/Internal Medicine (with Psych C/L team following) |
| Psychiatry | Psychiatrically ill patient with comorbid medical or infectious status requiring a higher level of nursing care and monitoring than provided in the psychiatric unit (as deemed by attending on service). This includes (but not limited to):   * Patients needing any form of IV treatments, tubes (including PEG tube feedings, chest tubes, catheters, airway devices), procedures, complex dressing changes. * Patients needing close monitoring of vitals (more frequent the Q6H), frequent labs, I/O monitoring, telemetry, or frequent imaging. | ICU/Internal Medicine (with Psych C/L team following) |
| Psychiatry | Patient unwilling or unable to be voluntarily admitted, or unwilling to consent to engage in the recommended treatment program, including an unwillingness to take the recommended medications if medications are part of anticipated treatment (this includes patients on active FD-12) | Transfer out |
| Psychiatry | Patient with known violent or disruptive behavior that would disrupt the milieu of a voluntary psychiatric unit | Transfer out |
| Pulmonary | COPD exacerbation/Asthma exacerbation/PE | Pulmonary-Blue Team/Internal |
| Pulmonary | Cystic Fibrosis flare, stable | Pulmonary-Blue Team /Internal |
| Pulmonary | Cystic Fibrosis flare, unstable | Pulmonary Determined-PCU vs ICU |
| Pulmonary | Non-traumatic pneumothorax/pneumomediastinum due to an underlying medical condition such as COPD or neoplasm excluding esophageal perforation not requiring a chest tube | Pulmonary-Blue Team /Internal  If chest tube required Thoracic Surgery |
| Pulmonary | Primary non-traumatic spontaneous pneumothorax/ pneumomediastinum | Thoracic Surgery |
| Pulmonary | Respiratory Distress or Respiratory Failure/Unstable | ICU |
| Pulmonary | Respiratory infection stable | Pulmonary - Blue Team /Internal Medicine after 5pm and weekends |
| Pulmonary | Saddle PE | ICU then Pulmonary team or Heart team as backup |
| Pulmonary | Symptoms r/t Pulmonary Fibrosis, stable | Pulmonary/Blue Team Determined-PCU vs Blue |
| Pulmonary | Symptoms r/t Pulmonary Fibrosis, unstable | Pulmonary/Blue Team Determined-PCU vs ICU |
| Pulmonary | Respiratory Distress or Respiratory Failure/Stable/Chronic | Pulmonary/Blue Team Determined- PCU vs Blue |
| Pulmonary | Lung mass/Lung Cancer | Pulmonary/Blue Team |
| Rheumatology | Any transfer/admission requiring rheumatology | Internal Medicine |
| Renal | ESRD with a nonspecific complaint such as fever or weakness without clear etiology, not followed at GWUH renal or renal transplant | Internal Medicine |
| Renal | ESRD with a nonspecific complaint such as fever or weakness without clear etiology, followed at GWUH renal | Internal Medicine |
| Renal | ESRD with a nonspecific complaint such as fever or weakness without clear etiology, followed at GWUH renal transplant | Renal Transplant |
| Renal | Patients coming in for renal biopsy | Renal Transplant |
| Renal | Recent renal transplant coming in with non-renal related issue | Renal Transplant if < 3 months post transplant  If < 3 months post transplant then Transplant Surgery |
| Renal | Renal Transplant recipient pre-op for transplant | Renal Transplant Surgery |
| **Return Patient** | Patient discharged from a service but returning within 48hours with a different complaint | ED/PLC– The discharging service unless new acute diagnosis is better served on other primary service |
| **Return Patient** | Patient discharged from a service but returning within 48hours with the same complaint | Service who Discharged |
| Sickle cell | SCC stable | Internal Medicine |
| Sickle cell | SCC unstable or with acute chest syndrome | ICU |
| Spine | Chronic back pain with Spinal Cord Stimulation System | Internal Medicine |
| Spine | Degeneration (disc herniation, stenosis, not cauda equine) non operative admission for pain control | Internal Medicine |
| Spine | Degeneration (disc herniation, stenosis, not cauda equine) requiring operative intervention | Ortho spine vs NSGY Spine alternating call ICU need determined by above ICU need determined by above service |
| Spine | Spinal infection or abscess with confirmed requirement for surgical intervention without active medical issues (e.g., AKI, poorly controlled DM/HTN, electrolyte abnormalities etc.) | Ortho-Spine/Neuro spine alternating call  ICU need determined by above service |
| Spine | Spinal infection or abscess with no requirement for surgical intervention OR with active medical issues (e.g., AKI, poorly controlled DM/HTN, electrolyte abnormalities etc.) | Internal Medicine |
| Spine | Traumatic spinal injury | Trauma |
| Spine | Tumor without active medical issues (e.g., AKI, poorly controlled DM/HTN, electrolyte abnormalities etc.) | Ortho-Spine/Neuro Spine alternating call |
| Spine | Tumor WITH (e.g., AKI, poorly controlled DM/HTN, electrolyte abnormalities etc.) | Internal Medicine |
| Surgical | Necrotizing fasciitis | Surgery for extremities, Urology for Fournier’s, Surgery for trunk or multiple areas (ICU as required) |
| Surgical | Primary psoas abscess | Internal Medicine |
|  | | |
| Surgical | SBO (non-IBD patients) | Surgery unless palliative or carcinomatosis, then Internal Medicine (or heme-onc if patient established with GWUH oncology) |
| Surgical | SBO (in patient with known IBD) | Internal Medicine |
| Surgical | Secondary psoas abscess due to nearby infection (spine hardware, THA, AAA graft, etc…) | Team managing the primary source of infection |
| Surgical | Breast abscess | Surgery |
| Surgical | Perianal/perirectal abscess | Colorectal surgery |
| Surgical | Obstructive uropathy in patient without active medical issues (e.g., poorly controlled DM/HTN, electrolyte abnormalities etc.) AKI is assumed | Urology |
| Trauma | Hanging/Suicide Attempt | Trauma vs Trauma ICU |
| Trauma | Patients needing admission for ADL’s/pain control r/t trauma | Trauma vs Trauma ICU |
| Trauma | Traumatic neck laceration | Trauma vs Trauma ICU |
| Trauma | Trauma to ear (tragus, auricle) | ENT |
| Trauma | Isolated Trauma to external auditory canal, tympanic membrane, or middle ear. Also, isolated mandible/maxilla fracture in patients without active medical issues (e.g., AKI, poorly controlled DM/HTN, electrolyte abnormalities etc.) | ENT |
| Trauma/Wound | Isolated large or complex soft tissue defects/lacerations from trauma or wound complications not involving bones | Trauma |
| Trauma | All injuries not otherwise noted above. When in doubt regarding triaging an injury, contact trauma first | Trauma |
| Vascular | Ruptured or symptomatic AAA | Vascular Surgery |
| Vascular | Ischemic foot or limb due to acute arterial occlusion | Vascular Surgery |

**Service Designation List Implementation Procedure**

The Service Designation List (SDL) will be utilized by the admitting ED attending for ED admissions, the Patient Logistic Center (PLC) staff for inbound transfers/Direct admits and the ICU Fellow/Attending for transfers out of the ICU. The SDL will guide the correct service designation driven by primary diagnosis. The goal is to ensure care is delivered in the right place at the right time and improve hospital efficiency.

In the event the receiving attending disagrees with the sending attending the following arbitration process applies

1. The on call attending physicians for the service(s) in question will discuss the case and ideally reach a resolution. If a resolution is not reached see #2
2. The on call medical director of the PLC will discuss the case with the on call attending(s) and determine the most appropriate service designation for the patient.