GWUH Service Designation List

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

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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

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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

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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

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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

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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

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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	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

discharge (TRAUMA)		
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

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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

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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

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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

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		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

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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

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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.

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