Primary Concern	Reason for Admission	Designated Team (in order of preference)
Cardiac	Potentially cardiac related problems (chest pain) in nephrology patients	Cardiology
Cardiac, Pulmonary	Patients with both heart failure and COPD with unclear primary etiology causing their acute problem	ED determined (ED attending to decide)
CNS	Acute Stroke, TIA	Stroke Service (Neurology)
CNS	Acute, nontraumatic, intracerebral hemorrhage	Stroke Service (Neurology)
CNS	Acute, repetitive seizures	Gen Neurology
CNS	Seizures of unknown cause	Gen Neurology
CNS	Status epilepticus	Gen Neurology (ICU)
CNS	ALS with decompensation or dyspnea not due to an acute infectious/metabolic problem	Gen Neurology
CNS	Concern with DBS (deep brain stimulation)	Gen Neurology
CNS	DBS system disruption or infection	Neurosurgery
CNS	DVT/PE in patient with known brain tumor	Gen Neurology
CNS	EEG-proven nonconvulsive status epilepticus	Gen Neurology
CNS	Hydrocephalus with VPS obstruction	Neurosurgery
CNS	Intracerebral Hematoma (Hypertensive stroke)	Neurology (per established protocol)
CNS	Limited(non-operative) non-traumatic subdural	Neurosurgery if SDH is extensive enough to require Q1h/Q2h neurochecks, otherwise Gen Medicine if SDH is small and pt has other active medical problems
CNS	Multiple Sclerosis acute exacerbation	Gen Neurology
CNS	Myasthenia gravis crisis	Gen Neurology
CNS	New brain tumor/mass	Neurosurgery if isolated or patient needs urgent CNS operation, otherwise Gen Med or Onc if patient has other masses that are likely primary source
CNS	Sudden worsening in patient status with previously diagnosed brain tumor (including mets) related to edema, seizures, mental status change	Gen Neurology attending to decide neurosurgery versus neurology
CNS	Critically ill patients with primary neurologic condition that need further stabilization or diagnostic procedures (such as MRI)	May admit to NeuroICU team with further team assignment as patient condition warrents

Primary Concern	Reason for Admission	Designated Team (in order of preference)
CNS	Periodic paralysis with acute weakness	Gen Neurology
CNS	Pituitary adenoma	Gen Medicine with Endocrine Consult
CNS	Pituitary apoplexy (with visual changes)	Neurosurgery
CNS	Possible acute Guillain Barre	Gen Neurology
CNS	Non-Traumatic subarachnoid hemorrhage (even if CTA normal)	Neurosurgery
CNS	Traumatic Brain Injury from limited trauma	Trauma (per established protocol)
CNS	VP Shunt with Fever	To neurosurgery with positive tap, else medicine
CNS	Massive stroke or CNS bleed deemed non-survivable.	Palliative care may choose to accept, otherwise to neurology or neurosurgery per primary SDL diagnosis.
Derm	Concern for SJS/TEN	Eval in ED by Derm then Burn Unit if SJS/TEN suspected. For other dermatologic care requiring hospitalization admit to GMD.
ENT	ENT abscess, nonodontogenic (whether drained in ED or not)	ENT
General	Non-VMG patients with a problem generally handled by a specialty service	ED determined - The same specialty service that would handle a similar VMG patient
GI Bleed	GI bleeds requiring an ICU	MICU
GI Bleed	Hemodynamically stable GI bleeds	Medicine
GI	Acute/chronic pancreatitis (without gallstones)	Medicine
GI	Gallstone pancreatitis	Rogers GI (EGS if capped)
GI	Cholecystitis	EGS
GI	Choledocolithiasis	Rogers GI (GMD if capped)
GI	Pancreatic pseudocyst with obstruction, bleeding, peritonitis	EGS (medicine if no obstruction/bleeding/peritonitis)
GI	Abdominal or pelvic abscesses requiring IR drainage	Primary surgical service or EGS if no prior VUMC service
GI	Complications of cirrhosis (non-bleeding, not followed by GI)	Riven Hospitalist
Hand	Non-surgical hand infections in a medically non-complex patient	Hand service on-call
Head&Neck Hemorrhage	Hemorrhage (severe) **above** the clavical (head and neck)	Involve In-house Trauma Attending (615-480-1149), Neuro IR, ENT, Vascular Surgery
Hemorrhage (severe)	Hemorrhage (severe) **below** the clavical (not head and neck)	In-house Trauma Attending (615-480-1149), Vascular Surgery, Interventional Radiology

Primary Concern	Reason for Admission	Designated Team (in order of preference)
ID	Catheter associated infections	ED determined - Service that is managing the catheter with ID consult as needed
ID	Osteomyelitis	Gen Medicine or ID at discretion of Medicine Triage Attending. Ortho if imminent surgery required (a level 1 or 2 case).
ID	Patients with HIV and an illness that would generally be handled by a subspecialty service	ID if followed by CCC, otherwise subspecialty service with RogersID consult
Medicine/Cardiac	Indeterminate or slightly elevated troponin levels in patients with another issue (hip fracture, pneumonia etc…)	Gen Medicine with cardiology consult
OB	<20 week pregnancy with a medical problem	Gen Med or Subspecialty Medicine with OB consult
OB	<20 week pregnancy with a surgical problem	Surgery with OB consult
Oncology	Newly diagnosed neoplasms without established tissue diagnosis	Gen Medicine (except new leukemia with >20% blasts goes directly to Brittingham)
Oncology	Oncology patients followed by Non-VMG oncologists	Gen Medicine, (ED Hematology/Oncology consult)
Oncology	Oncology patients followed by VMG oncologists where the primary cause of admission is active cancer, complication of cancer therapy, or late effects of cancer	Oncology
Oncology	Oncology patients followed by VMG oncologists who are being admitted for non-cancer related diagnoses	Team as determined by the SDL related to the primary admitting diagnosis
Ophthalmology	Isolated ocular infections	Rogers ID team with Ophtho consult (Riven/Morgan if Rogers ID is capped)
Ophthalmology	Isolated ocular trauma or mass in patients with poorly controlled/significant medical comorbidities	Ophthalmology with a medicine consult
Ophthalmology	Isolated ocular trauma or mass in patients with stable medical comorbidities	Ophthalmology
Ortho	Septic joints in a medically non-complex patient	Ortho (may consult medicine after admission if evaluation for source is needed)
Ortho	Isolated operative extremity fractures in a medically non-complex patient with no indication of internal organ injury	Ortho (Trauma may be consulted but should not delay admission)
Ortho	Isolated operative extremity/pelvic fractures in a patient with stable medical problems that did NOT lead to the fracture (e.g. HTN, DM, CRI)	Ortho Trauma with General Medicine consult after admission [includes geri hip fx]

Primary Concern	Reason for Admission	Designated Team (in order of preference)
Ortho	Isolated operative extremity/pelvic fractures in a patient with active medical problems that did NOT lead to the fracture, but need medical treatment prior to fracture repair (e.g. AKI, severe hyponatremia, DKA)	General Medicine or Geri (>65) with an Ortho consult upon admission
Ortho	Isolated operative extremity/pelvic fractures in a patient with active medical problems that lead to the fracture (e.g. syncope, TIA, AMS as determined by ED attending)	General Medicine or Geri (>65) with an Ortho consult upon admission
Podiatry	Podiatry complications	Gen Medicine. Ortho if imminent surgery required (a level 1 or 2 case) or hemorrhagic complications.
Postop, NEW medical issue after surgical discharge (Non-Ortho)	New (but related) medical complications such as DVT/PE or Pneumonia following surgery	Gen Medicine if >14 days after surgical discharge
Postop, NEW medical issue after surgical discharge (Ortho)	New (but related) medical complications such as DVT/PE or Pneumonia following surgery	Gen Medicine if >48 hours after surgical discharge
Pulmonary	COPD exacerbation due to supplemental oxygen fire	Burn team
Pulmonary	Primary non-traumatic spontaneous pneumothorax/pneumomediastinum	Thoracic Surgery
Pulmonary	Non-traumatic pneumothorax/pneumomediastinum due to an underlying medical condition such as COPD or neoplasm excluding esophageal perforation	Medical/pulmonary team associated with the primary condition and a thoracic surgery consult as appropriate
Pulmonary	Patient on a home vent being admitted for a non-pulmonary issue and hemodynamically stable for a med/surg bed	Assign primary physician team per SDL, nursing care provided in an ICU or 5South bed (which unit determinted by the Patient Flow Center). The intensivist team may be consulted for vent overwatch.
Renal	A nephrology related illness but the patient isn't followed by a VMG nephrologist.	Renal (Medicine)
Renal	Dialysis shunt related complications due to infections	Renal Transplant (Surgery)
Renal	Dialysis shunt related complications due to clotting	Renal (Medicine)
Renal	ESRD with a nonspecific complaint such as fever or weakness without clear etiology.	Renal if VMG patient, otherwise Gen or Subspecialty Medicine with Renal consult

Primary Concern	Reason for Admission	Designated Team (in order of preference)
Return Patient	Patients discharged from a service but returning within 48 hours with a different complaint	ED determined - The discharging service unless extenuating circumstances
Sickle Cell	Sickle cell crisis with complications (acute chest, fever, PE, elev trop, hypoxia etc...)	General Medicine (Sickle Cell service if uncomplicated)
Spine	Chronic back pain with Spinal Cord Stimulation System	Gen Medicine
Spine	Degeneration (disc herniation, stenosis), not cauda equina	Gen Medicine
Spine	Infection	Inf Dis Medicine
Spine	Spinal stimulation system hardware failure or infection	Neurosurgery
Spine	Trauma (fractures)	Trauma (per established protocol)
Spine	Tumor	Spine Surgery (Ortho/NSG)
Surgical	Small bowel obstructions (non-IBD patients)	EGS unless palliative care or carcinomatosis
Surgical	Small bowel obstruction (in patient with known IBD)	Colorectal Surgery if complete SBO, otherwise Rogers GI (or GMD if capped)
Surgical	Primary psoas abscess	ID
Surgical	Potential surgical problems in a patient with multiple medical	Surgery with a medicine consult
Surgical	Secondary psoas abscess due to nearby infection (spine hardware, THA, AAA graft etc)	Team that manages the primary source of infection with EGS consult as needed
Surgical	Necrotizing Fasciitis	Ortho Trauma for extremities, Urology for groin, EGS for trunk or multiple areas
Toxicology	Intubated CO exposure	Burn ICU if from structure fire, otherwise MICU
Toxicology	Non-intubated CO exposure	Burn team if patient has cutaneous burns, otherwise Medicine with tox consult. If a family needs overnight O2 and has no other injuries the patients remain cohorted under EM management in the adult or pedsED
Transplant	Cardiac transplant patient	Determined by cardiac transplant attending
Transplant	Lung transplant patient	Pulmonary medicine unless a clearly surgical problem
Transplant	Liver transplant patient	HBS if <90 days post-transplant or a clearly surgical problem, otherwise hepatology

Primary Concern	Reason for Admission	Designated Team (in order of preference)
Transplant	Renal transplant patient	Renal transplant surgery if <30 days post- transplant or a clearly surgical problem, otherwise nephrology
Trauma	Isolated non-operative extremity/pelvic fractures or patients needing admission for ADL's/pain control	Trauma T3 Service, except GenMed/Geri if: - patient is >65y/o or - has decompensated medical comorbidities or - needs a medical workup for the proximate cause of the injuries
Trauma	Complex neck lacerations	Trauma team
Trauma	Trauma to external ear (tragus, auricle)	Facial trauma on call team
Trauma	Trauma to external auditory canal, tympanic membrane, or middle ear	ENT
Trauma	Complex scalp lacerations	Facial trauma on call team
Trauma	Hanging	Trauma if C-Spine fx or vasc injury, neuroICU team if intubated due only to anoxic brain injury
Trauma/Wound	Isolated large or complex soft tissue defects/lacerations from trauma or wound complications not involving bones	Plastics

VUMC Operational Policy 10-20.05 Management of Emergent Transfers to VUMC

1. Requests for transfers are coordinated through the Access Center.
2. The Emergency Department (ED) attending or service specific accepting physician coordinates an appropriate transfer with the VUMC Access Center staff and the referring provider/facility. Any denial or delay of accepting an EMC transfer is escalated to the supervisor immediately.
NOTE: The ED attending has the authority to accept patients.
3. For patients that require hospital admission, it is the accepting physician or designee's responsibility to admit the patient or secure another admitting physician and primary service. If the patient was accepted by the ED that responsibility lies with the attending physician on the primary service designated by the ED.
4. Patients accepted by the ED are assigned to a primary service by the ED attending. It is the accepting physician or designee's responsibility to admit and treat the patient, or to secure and transfer the patient to another admitting physician and primary service.

Policy Effective Date: August 2012, Passed by the Medical Center Medical Board June 2012