

EMORY UNIVERSITY HOSPITAL

at Wesley Woods

Fax Numbers:

Unit A: (404) 728-4941

Unit B: (404) 728-6592

Psych Access Services

Medical Stability / Exclusionary

Emory University Hospital at Wesley Woods is an inpatient psychiatric hospital with a limited capacity to safely manage certain comorbid general medical conditions of patients presenting with psychiatric disorders. Therefore, the referring facility and physician shall satisfy Emory University at Wesley Woods and accepting physician that the patient is medically stable and suitable for treatment at Emory University Hospital at Wesley Woods according to criteria listed below. Prospective patients who fail to meet these criteria are best managed in another hospital with greater medical capabilities. These criteria require clinical judgment and should not be applied rigidly. Exceptions may be made after consulting with the patient's attending physician or prospective attending physician and/or Nursing Manager. Please note, Emory University Hospital at Wesley Woods **does not** accept 1013 patients. Patients must first be converted to a 1014, with all supporting documentation faxed to EUH@WW prior to consideration for admissions.

PATIENT'S NAME: _____

REFERRING FACILITY: _____

REFERRING PHYSICIAN: _____

REASON FOR ADMISSION: _____

VITAL SIGNS: BP _____ T _____ P _____ R _____ TIME: _____

(*) Contact Physician (MD) and/or Nurse Manager (NM) for approval

YES	NO	MEDICAL LAB RESULTS
<input type="checkbox"/>	<input type="checkbox"/>	1. Do laboratory values and other assessments exceed any of these critical values? If so, patient must be stabilized within one hour prior to acceptance, actions taken and new values must be documented.
<input type="checkbox"/>	<input type="checkbox"/>	A. Hypertension – BP >Systolic >180 must be evaluated and treated with follow-up BP (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	B. Hypotension – BP Systolic < 80 and/or symptomatic (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	C. Temperature of 101° or above must first be evaluated
<input type="checkbox"/>	<input type="checkbox"/>	D. Pulse less than 50 or greater than 130 per minute must first be evaluated
<input type="checkbox"/>	<input type="checkbox"/>	E. Anemia, Hgb < 8 requires work up or explanation (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	F. Uncontrolled diabetes. Blood sugar must be stabilized consistently below 300 mg/dl. (*MD) or less than 70 mg/dl.

<input type="checkbox"/>	<input type="checkbox"/>	G. Hypokalemia levels below 3.3 must be treated and level repeated with appropriate response to treatment verified prior to transfer
<input type="checkbox"/>	<input type="checkbox"/>	H. Hyponatremia level below 130 must be normalized prior to transfer
<input type="checkbox"/>	<input type="checkbox"/>	I. Acute infection with white blood cells below 12.5 lab values (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	J. Creatinine kinase level above 2,000 with 2 repeat CK showing downward trend
<input type="checkbox"/>	<input type="checkbox"/>	K. Abnormal EKG requiring medical intervention
<input type="checkbox"/>	<input type="checkbox"/>	L. Acetaminophen levels, suspected suicide or OD (value of 2 levels or downward trend, if OD) (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	M. Sepsis
<input type="checkbox"/>	<input type="checkbox"/>	N. Positive pregnancy test? Test Date: _____. < 20 weeks for admission to WWH.
YES	NO	INFECTION CONTROL
<input type="checkbox"/>	<input type="checkbox"/>	2. Does the patient have any of these infections/illnesses?
<input type="checkbox"/>	<input type="checkbox"/>	A. Pulmonary tuberculosis – if yes, R/O status documented by ED MD
<input type="checkbox"/>	<input type="checkbox"/>	B. Any infectious illness requiring isolation, such as airborne isolation
<input type="checkbox"/>	<input type="checkbox"/>	C. Cardiac disease, unstable including Bradycardia below 60/minute, symptomatic, persistent (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	D. Cardiac disease, unstable including Tachycardia above 120/minute, symptomatic, persistent (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	E. Unhealed decubitus ulcers (stage 3 & above), open wounds, severe burns or unresolved cellulitis (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	F. Uncontrolled and active infectious disease requiring isolation and/or treatment by IV antibiotic (*MD) IV antibiotics are fine so long as patient has access, would otherwise be appropriate for outpatient care/VNA
<input type="checkbox"/>	<input type="checkbox"/>	G. Influenza – type illness
<input type="checkbox"/>	<input type="checkbox"/>	H. End-stage disease including, but not limited to cancer and AIDS (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	I. Gastrointestinal bleeding – active
<input type="checkbox"/>	<input type="checkbox"/>	J. Diarrhea, suspected with infection – if yes, must R/O C. Diff (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	K. Active Lice and/or scabies – if yes, treatment must be initiated by ED, 24 hours prior. Last Treatment Date: _____ (*NM)
<input type="checkbox"/>	<input type="checkbox"/>	L. Active and undiagnosed rash – requires explanation (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	M. Orthopedic condition including fracture or joint dislocation - unstable
YES	NO	VIOLENT, ASSAULT, CRIMINAL HISTORY
<input type="checkbox"/>	<input type="checkbox"/>	3. Does patient have a history of violence and/or charges pending? (*MD/NM) If so, specify: <ul style="list-style-type: none"> • Does patient have a history of violence and/or incarceration? If so, please explain reasoning and judgement behind each:
YES	NO	CLINICAL SUPPORT CONSIDERATIONS
<input type="checkbox"/>	<input type="checkbox"/>	4. Does the patient have or require any of the following?
<input type="checkbox"/>	<input type="checkbox"/>	A. Tracheostomy (trach) (*MD/NM)
<input type="checkbox"/>	<input type="checkbox"/>	B. Indwelling tubing, including percutaneous, nasogastric (*MD) we can manage these
<input type="checkbox"/>	<input type="checkbox"/>	C. Renal or peritoneal dialysis
<input type="checkbox"/>	<input type="checkbox"/>	D. Scheduled or PRN suctioning
<input type="checkbox"/>	<input type="checkbox"/>	E. Physical Therapy
<input type="checkbox"/>	<input type="checkbox"/>	F. Ventilator

<input type="checkbox"/>	<input type="checkbox"/>	G. If on CPAP, patient must provide their own equipment and supplies.
<input type="checkbox"/>	<input type="checkbox"/>	H. Oxygen Therapy; condensers may deliver oxygen, however, not continuous or over 2 liters.
<input type="checkbox"/>	<input type="checkbox"/>	I. Bariatric bed that exceeds maximum weight of 500lbs. Bariatric bed needs to be requested within 24 hours for patient admission (*NM)
		J. Ostomies (*NM) patient must provide their own equipment and supplies for two days initially
YES	NO	ACTIVITIES OF DAILY LIVING (ADL)
<input type="checkbox"/>	<input type="checkbox"/>	5. Is the patient bedfast and incapable of ambulating independently or with the help of a guided cane or walker? May accept patients in a wheelchair, must be fully functional. Is patient a one person assist for transfers.
<input type="checkbox"/>	<input type="checkbox"/>	6. Is the patient capable of performing ADL independently? (*NM). Are there ADL limitations? If so, specify:
YES	NO	COGNITIVE OR INTELLUCTUAL IMPAIRMENT
<input type="checkbox"/>	<input type="checkbox"/>	7. Does the patient have any of the following impairments that would preclude active participation in group therapies, individual and family therapy, and any other psychosocial programming?
<input type="checkbox"/>	<input type="checkbox"/>	A. Intellectual Deficit Disorders – IQ below 70 – (i.e. mental retardation, pervasive developmental disorders)
<input type="checkbox"/>	<input type="checkbox"/>	B. Alzheimer’s Disease and Dementia
<input type="checkbox"/>	<input type="checkbox"/>	C. Delirium
<input type="checkbox"/>	<input type="checkbox"/>	D. Recent stroke
<input type="checkbox"/>	<input type="checkbox"/>	E. Traumatic Brain Injury – if unable to participate in milieu
<input type="checkbox"/>	<input type="checkbox"/>	F. Active and debilitating medical illness, including neuromuscular diseases, requiring physical therapy during hospitalization
<input type="checkbox"/>	<input type="checkbox"/>	G. Is subdural hematoma suspected? May request CT of brain.
YES	NO	AGE EXCLUSION
<input type="checkbox"/>	<input type="checkbox"/>	8. Is the patient 18-years of age or older?
YES	NO	ALCOHOL & SUBSTANCE USE/ABUSE
<input type="checkbox"/>	<input type="checkbox"/>	9. Does the patient present with signs of alcohol abuse, dependency or intoxication?
<input type="checkbox"/>	<input type="checkbox"/>	A. CIWA Assessment or equivalent clinical evaluation of withdrawal symptoms including, but not limited to: blood alcohol level is <80, tremor, diaphoresis, myalgia. CIWA Score less than 12, anything above requires (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	B. Does patient have a history of withdrawal with delirium tremors? (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	C. Does patient have a history of ICU admission for withdrawal? (*MD)
<input type="checkbox"/>	<input type="checkbox"/>	D. LFT
<input type="checkbox"/>	<input type="checkbox"/>	E. May request labs such as amylase or lipase to rule out other medical etiologies
<input type="checkbox"/>	<input type="checkbox"/>	10. Does the patient present with Substance Use/Abuse as the primary problem ; active overdose, Detox requiring medical clearance? (*MD)

I hereby acknowledge I have assessed this patient and determined him/her to be medically stable and appropriate for admission into Emory University Hospital at Wesley Woods.

Reviewed by Psych Access:

Which MD/NM did you partner with?

Date/Time: