

Appendix 1

Emergency Department Observation Unit Protocols

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Source: Used with permission of the Brigham and Women's

Hospital, March 2010



ABDOMINAL PAIN

I. Exclusion Criteria:

- A. Chronic abdominal pain
- B. Acute peritonitis
- C. Hypotension
- D. Anticipated OBS LOS < 4-6 hours (use Transition protocol).
- E. Probability of discharge within 24 hours < 80%

II. Typical OBS Interventions:

- A. NPO except meds
- B. IV hydration
- C. Symptomatic control with meds (antiemetics, narcotics, GI cocktail)
- D. Serial exams and vital signs
- E. Abdominal imaging as indicated
- F. General surgery or other consultation as indicated

III. <u>Disposition Criteria:</u>

A. HOME

- 1. Resolution or significant improvement of pain
- 2. Completion of diagnostic evaluation

B. HOSPITAL

- 1. Abnormal imaging requiring hospitalization
- 2. Persistent nausea or vomiting, inability to hydrate as outpatient

IV. Time Frame:

A. 8-24 hour observation





ED OBSERVATION ADMIT NOTE Please date and sign each entry DATE: TIME: PROTOCOL: ABDOMINAL PAIN RELEVANT HISTORY/PHYSICAL FINDINGS: Family History: □ reviewed and noncontributory □ other: Social History: ☐ reviewed and noncontributory □ other: OBS INTERVENTIONS: □ NPO ☐ Serial exams ☐ Imaging ☐ Consultations: ☐ IV hydration ☐ Repeat labs ☐ Serial exams ☐ Other: MEDICAL DECISION MAKING / GOAL OF OBSERVATION PERIOD: HOW OFTEN WILL PATIENT BE EVALUATED BY MD/PA: □ Q4H □ Q6H □ Q8H □ Q shift MORNING PLAN: RESIDENT / PA (circle) SIGNATURE: (PRINTED): PCP CONTACTED: Y NAME: N THE NEXT SECTION TO BE COMPLETED ONLY BY THE ATTENDING PHYSICIAN.

☐ I HAVE INTERVIEWED AND EXAMINED THIS PATIENT AND I AGREE WITH THE

VISIT RECORD FOR FURTHER DETAIL.

SIGNATURE:

OBSERVATION ADMISSION AND PLAN OF CARE AS DESCRIBED ABOVE. PLEASE SEE ED

(PRINTED):

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TIME:			
PRESENTING COMPLAIN	NT:		
OBSERVATION COURSE):		
☐ Pain improved	☐ Imaging reviewed	□ Consulta	tions:
☐ IV hydration	☐ Labs reviewed	□ Relevant	Physical Exam and VS reviewed
DISPOSITION:			
DISCHARGE DIAGNOSIS	S:		
DISCHARGE INSTRUCTI	ONS GIVEN: Y	N	
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ALLERGIC REACTION

I. Exclusion Criteria:

- A. Stridor or other evidence of actual or impending airway compromise
- B. Room air oxygen saturation < 90%
- C. Hypotension
- D. Probability of discharge within 24 hours < 80%

II. Typical OBS Interventions:

- A. IV fluids
- B. Antihistamines
- C. Corticosteroids
- D. Albuterol ± ipratropium
- E. Monteleukast
- F. Telemetry and oxygen saturation monitoring
- G. Airway monitoring
- H. Epi-pen teaching

III. Disposition Criteria:

A. HOME

1. Improvement in clinical condition

B. HOSPITAL

1. No improvement in clinical condition

IV. Time Frame:

A. 8-24 hour observation

NOT A PART OF THE MEDICAL RECORD





Please date and sign each entry		ED OBSERVATION ADMIT NOTE
DATE:		
TIME:		
PROTOCOL: ALLERGIC	REACTION	
RELEVANT HISTORY/PHY	YSICAL FINDINGS:	
Family History: □ reviewed an	nd noncontributory	
□ other:		
Social History: reviewed and	nd noncontributory	
□ other:		
OBS INTERVENTIONS:		
☐ Hydration	☐ Corticosteroids	☐ Bronchodilator Treatments
☐ Antihistamines	☐ Pulse Oximeter monitoring	☐ Other:
MEDICAL DECISION MAK	KING / GOAL OF OBSERVATION F	PERIOD:
HOW OFTEN WILL PATIE	NT BE EVALUATED BY MD/PA: [□ Q4H □ Q6H □ Q8H □ Q shift
MORNING PLAN:		
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DATE:
TIME:
PRESENTING COMPLAINT:
OBSERVATION COURSE:
☐ Hydration ☐ Antihistamines ☐ Corticosteroids ☐ Epi Pen Rx
☐ Bronchodilator Treatments ☐ Relevant Physical Exam and Vital Signs Reassessed
DISPOSITION:
DISCHARGE DIAGNOSIS:
DISCHARGE INSTRUCTIONS GIVEN: Y N
PRIMARY PHYSICIAN CONTACTED: Y N NAME:
WHAT FOLLOW-UP HAS BEEN ARRANGED:
RESIDENT / PA (circle) SIGNATURE: (PRINTED):

THE NEXT SECTION TO BE COMPLETED ONLY BY THE <u>ATTENDING PHYSICIAN</u> .
☐ I HAVE INTERVIEWED AND EXAMINED THIS PATIENT AND PARTICIPATED IN THE DISCHARGE FROM OBSERVATION. I AGREE WITH THE DISCHARGE ARRANGEMENTS ABOVE.
□ PLEASE SEE MY DICTATED NOTE ON THIS PATIENT. DICTATION #:
SIGNATURE: (PRINTED): ID #:



ASTHMA

I. <u>Exclusion Criteria:</u>

- A. RR >40
- B. Impending respiratory fatigue/failure
- C. Inability to perform spirometry
- D. Pulse oximeter < 90% on room air
- E. Need for continuous nebulizer treatments, BIPAP, or heliox

II. <u>Typical OBS Interventions:</u>

- A. Serial exams including vital signs every 4 hours
- B. Pulse oximeter monitoring
- C. Supplemental oxygen
- D. Serial peak-flow measurements
- E. Bronchodilator treatments every 1-4 hours
- F. Steroids
- G. Asthma/MDI teaching

III. <u>Disposition Criteria:</u>

A. HOME

- 1. Major resolution of SOB / wheezing
- 2. Ambulating comfortably without significant O₂ desaturation

B. **HOSPITAL**

- 1. Deterioration of condition
- 2. Peak flow deterioration to < 20% expected
- 3. RR >35
- 4. Pulse oximeter < 90% on room air for 30 minutes

IV. <u>Time Frame:</u>

A. 8-24 hour observation

NOT A PART OF THE MEDICAL RECORD





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DATE:		
TIME:		
PROTOCOL: ASTHMA		
RELEVANT HISTORY/PHYSICAL FINDINGS:		
Family History: reviewed and noncontributory		
□ other:		
Social History:		
□ other:		
OBS INTERVENTIONS:		
☐ Serial exams including vital signs every 4 hrs	☐ Bronchodilators ☐ Asthma/MDI teaching	
☐ Pulse oximeter monitoring	☐ Hydration	
☐ Supplemental oxygen	□ Steroids	
MEDICAL DECISION MAKING / GOAL OF OBSERVATIO	N PERIOD:	
HOW OFTEN WILL PATIENT BE EVALUATED BY MD/PA	A: □ Q4H □ Q6H □ Q8H □ Q shift	
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PEAK FLOW RECORDS



Pre Treatment Assessment Time:	Pre Treatment Assessment Time:
Peak Flow: % Predicted:	Peak Flow: % Predicted:
Signature:	Signature:
Pre Treatment Assessment Time: Peak Flow: % Predicted:	Pre Treatment Assessment Time: Peak Flow: % Predicted:
Signature:	Signature:
Pre Treatment Assessment Time: Peak Flow: % Predicted:	Pre Treatment Assessment Time: Peak Flow: % Predicted:
Signature:	Signature:





Please date and sign each entry	ED OBSERVATION	N DISCHARG	E NOTE	
DATE:				
TIME:				
PRESENTING COMPLAINT:				
OBSERVATION COURSE:				
☐ Corticosteroids ☐	Bronchodilators	□ Pe	eak flow reviewed	
☐ Ambulatory saturation rev	iewed	□ R	elevant Physical Exa	m and Vital Signs reviewed
DISPOSITION:				
DISCHARGE DIAGNOSIS:				
DISCHARGE INSTRUCTIONS GIVEN:		N		
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BACK PAIN

I. <u>Exclusion Criteria:</u>

- A. Significant trauma involving other systems or other sites
- B. Acutely deteriorating neurologic exam
- C. Probability of discharge within 24 hours < 80%

II. <u>Typical OBS Interventions:</u>

- A. Serial exams
- B. Analgesics
- C. Physical Therapy assessment
- D. Consultation
- E. Imaging

III. <u>Disposition Criteria:</u>

A. HOME

- 1. Ability to tolerate pain on PO medication
- 2. Stable neurological exam

B. HOSPITAL

- 1. Inability to control pain with PO medication after 24 hour observation
- 2. Diagnosis requiring an inpatient admission

IV. Time Frame:

A. 8-24 hour observation

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PROTOCOL: BACK PAIN		
RELEVANT HISTORY/PHYSICAL F	FINDINGS:	
Family History: ☐ reviewed and noncont	ributory	
□ other:		
Social History:	ributory	
□ other:		
OBS INTERVENTIONS:		
☐ Serial exams	☐ Physical Therapy assessment	☐ Imaging:
☐ Analgesics	☐ Consultation:	
MEDICAL DECISION MAKING / GOAL	OF OBSERVATION PERIOD:	
HOW OFTEN WILL PATIENT BE E	VALUATED BY MD/PA: □ Q4H	□ Q6H □ Q8H □ Q shift
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DATE: TIME: PRESENTING COMPLAINT: OBSERVATION COURSE: Imaging reviewed	Please date and sign each entry ED OBSERVATION DISCHARGE NOTE
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THE NEXT SECTION TO BE COMPLETED ONLY BY THE ATTENDING PHYSICIAN. □ I HAVE INTERVIEWED AND EXAMINED THIS PATIENT AND PARTICIPATED IN THE DISCHARGE FROM OBSERVATION. I AGREE WITH THE DISCHARGE ARRANGEMENTS ABOVE.	RESIDENT / PA (circle) SIGNATURE: (PRINTED):
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CELLULITIS

I. Exclusion Criteria:

- A. Suspicion for necrotizing fasciitis, Fournier's gangrene or Ludwig's angina
- B. Suspected sepsis
- C. Probability of discharge within 24 hours < 80%

II. Typical OBS Interventions:

- A. Antibiotics
- B. Analgesics and Anti-inflammatories
- C. Elevation/immobilization
- D. Consultation, if indicated
- E. Imaging, if indicated.
- F. Home care coordination, if indicated

III. <u>Disposition Criteria:</u>

A. HOME

- 1. Improvement in clinical condition
- 2. Tolerating medications

B. **HOSPITAL**

- 1. Spread of infection
- 2. Signs of systemic illness

IV. <u>Time Frame:</u>

A. 8-24 hour observation





SIGNATURE:

Please date and sign each entry	ED OBSERVATION ADMIT NOTE
DATE:	
TIME:	
PROTOCOL: CELLULITIS	
RELEVANT HISTORY/PHYSICAL FINDING	S:
Family History: □ reviewed and noncontributory	
□ other:	
Social History: □ reviewed and noncontributory	
□ other:	
OBS INTERVENTIONS:	
☐ Antibiotics ☐ Serial Exams	Elevation/Immobilization
☐ Analgesics/Anti-inflammarories	☐ Consultation: ☐ Other:
MEDICAL DECISION MAKING / GOAL OF	OBSERVATION PERIOD:
HOW OFTEN WILL PATIENT BE EVALUATED	BY MD/PA: □ Q4H □ Q6H □ Q8H □ Q shift
MORNING PLAN:	
RESIDENT / PA (circle) SIGNATURE:	(PRINTED):
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DATE:		
TIME:		
PRESENTING COMPLAINT:		
OBSERVATION COURSE:		
☐ Antibiotics ☐ Home care coordination ☐ Elevation/Immobilization		
☐ Analgesia ☐ Relevant Physical Exam and VS reviewed		
DISPOSITION:		
DISCHARGE DIAGNOSIS:		
DISCHARGE INSTRUCTIONS GIVEN: Y N		
PRIMARY PHYSICIAN CONTACTED: Y N NAME:		
WHAT FOLLOW-UP HAS BEEN ARRANGED:		
RESIDENT / PA (circle) SIGNATURE: (PRINTED):		

THE NEXT SECTION TO BE COMPLETED ONLY BY THE ATTENDING PHYSICIAN.		
☐ I HAVE INTERVIEWED AND EXAMINED THIS PATIENT AND PARTICIPATED IN THE DISCHARGE FROM OBSERVATION. I AGREE WITH THE DISCHARGE ARRANGEMENTS ABOVE.		
□ PLEASE SEE MY DICTATED NOTE ON THIS PATIENT. DICTATION #:		
SIGNATURE: (PRINTED): ID #:		



CHEST PAIN

I. <u>Exclusion Criteria:</u>

- A. Ischemic EKG changes
- B. Troponin or CKMB percentage newly positive
- C. Probability of discharge home within 24 hours < 80%

II. <u>Typical OBS Interventions:</u>

- A Monitor vital signs
- B. Telemetry
- C. Serial EKG's at 0 and 6 hrs, and with any recurrent pain
- D. Cardiac markers at 0 and 6 hrs from arrival in ED, unless otherwise ordered
- E. Provocative testing (ETT, MIBI, ECHO) or coronary CT at attending discretion

III. <u>Disposition Criteria:</u>

A. HOME

- 1. ED attending does not suspect cardiac ischemia
- 2. No elevations in TnT or CKMB percentage
- 3. Results of any imaging or provocative testing reviewed

B. HOSPITAL

- 1. Ischemia suspected
- 2. Abnormal vital signs other than mild or moderate hypertension

IV. Time Frame:

A. 8-24 hour observation

NOT A PART OF THE MEDICAL RECORD





SIGNATURE:

Please date and sign each entry ED OBSERVATION	ADMIT NOTE	
DATE:		
TIME:		
PROTOCOL: CHEST PAIN		
RELEVANT HISTORY/PHYSICAL FINDINGS:		
Symptoms/chief complaint:	Family History:	☐ reviewed and noncontributory
EKG:		□ other:
CAD risk factors:	Social History:	☐ reviewed and noncontributory
Previous Stress/Cath dates & results:		□ other:
OBS INTERVENTIONS:		
☐ Monitor vital signs	☐ Telemetry at ED att	ending's discretion
☐ ECG at 0 and 6 hours, and with any recurrent CP if not, explain rationale:	Cardiac markers at if not, explain ration	
□ Provocative testing: (should be NPO for 6 hours) □ Standard ETT □ Nuclear study □ Stress ECHO □ Coronary CTA □ No test from OBS} explain rationale		
GOAL OF OBSERVATION PERIOD:		
HOW OFTEN WILL PATIENT BE EVALUATED BY MD/ PA:	□ Q4H □ Q6H	□ Q8H □ Q shift
MORNING PLAN:		
RESIDENT / PA (circle) SIGNATURE	(PRIN	VTED)
PCP CONTACTED: Y N NAME:		
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☐ I HAVE INTERVIEWED AND EXAMINED THIS I OBSERVATION ADMISSION AND PLAN OF CAR VISIT RECORD FOR FURTHER DETAIL.		

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DATE:					
TIME:					
PRESENTING COMPLAINT:					
OBSERVATON COURSE:					
□ 0 hr CKMB %		hr CKM	В %		☐ CXR reviewed
□ 0 hr TnT reviewed		5 hr TnT			☐ Relevant Physical Exam and VS
☐ Provocative test or CTA	A result:				
DISPOSITION:					
DISCHARGE DIAGNOSIS:					
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□ PLEASE SEE MY DICTAT	ED NOTI	E ON TH	IS PAT	IENT.	DICTATION #:
SIGNATURE:			(PRI	NTED):	ID #:



DEHYDRATION

I. <u>Exclusion Criteria:</u>

- A. Severe dehydration
- B. Concomitant acute severe medical condition (i.e., acute renal failure, sepsis)
- C. 130 < Na >155 mEq or hemodynamic instability
- D. Probability of discharge within 24 hours < 80%

II. Typical OBS Interventions:

- A. IV Hydration
- B. Serial exams and vital signs
- C. Antiemetic
- D. Repeat labs

III. <u>Disposition Criteria:</u>

A. HOME

- 1. Resolution of symptoms
- 2. Stable vital signs

B. **HOSPITAL**

1. Inability to correct symptoms after 24 hours of observation

IV. Time Frame:

A. 8-24 hour observation

NOT A PART OF THE MEDICAL RECORD



Please date and sign each entry.		El	O OBSERVATION ADMIT NOTE
DATE:			
TIME:			
PROTOCOL: DEHYDRATION			
RELEVANT HISTORY/PHYSIC	AL FINDINGS:		
Family History: ☐ reviewed and no	ncontributory		
Social History: reviewed and no	ncontributory		
OBS INTERVENTIONS:			
☐ Serial exams	☐ IV hydration	☐ Antiemetic	
☐ Repeat labs	☐ Advance diet	☐ Other:	
MEDICAL DECISION MAKING	/ GOAL OF OBSERVATI	ON PERIOD:	
HOW OFTEN WILL PATIENT E	BE EVALUATED BY MD/	PA: □ Q4H □ Q6H	□ Q8H □ Q shift
MORNING PLAN:			
RESIDENT / PA (circle)	SIGNATURE:		(PRINTED):
PCP CONTACTED:	Y N NAI	ME:	
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THE NEXT SECTION TO BE	C COMPLETED ONLY	BY THE ATTENDIN	G PHYSICIAN.
			EE WITH THE OBSERVATION SEE ED VISIT RECORD FOR
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Please date and sign each entry

ED OBSERVATION DISCHARGE NOTE





DATE:					
TIME:					
PRESENTING COMPLAINT:					
OBSERVATION COURSE:					
☐ Labs reviewed	□ R	Relevant 1	Physical Ex	am and VS reviewed	
DISPOSITION:					
DISCHARGE DIAGNOSIS:					
DISCHARGE INSTRUCTIONS GIVEN:	Y	N			
PRIMARY PHYSICIAN CONTACTED:	Y	N	NAME:		
WHAT FOLLOW-UP HAS BEEN ARRANG	GED:				
RESIDENT / PA (circle) SIGNATU	RE:			(PRINTED):	
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THE NEXT SECTION TO BE COMPLETE	ED ONL	Y BY TH	IE ATTEN	DING PHYSICIAN.	
☐ I HAVE INTERVIEWED AND EXAM FROM OBSERVATION. I AGREE V	IINED T	THIS PA HE DIS	TIENT ALCHARGE	ND PARTICIPATED IN ARRANGEMENTS AB	N THE DISCHARGE OVE.
□ PLEASE SEE MY DICTATED NOTE				ICTATION #:	
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VENOUS THROMBOEMBOLIC DISEASE

I. Exclusion Criteria:

- A. Documented or highly suspected PE
- B. Complex DVT requiring catheter-directed thrombolysis
- C. Complicating illness
- D. Probability of discharge within 24 hours < 80%

Note: This pathway is not meant for workup of patients with isolated calf DVT

II. <u>Typical OBS Interventions:</u>

- A. Weigh Patient
- B. Monitor VS & oxygen saturation
- C. Check appropriate lab tests (CBC, Creatinine, PT/INR, UHCG)
- D. Initiate low molecular weight heparin (LMWH)
- E. Imaging studies
- F. Initiate warfarin therapy
- G. LMWH and warfarin teaching

III. <u>Disposition Criteria:</u>

A. HOME

- 1. Adequate home support
- 2. Teaching completed
- 3. Appropriate follow up arranged

B. **HOSPITAL**

- 1. Deterioration in clinical status
- 2. Newly diagnosed PE
- 3. Need for unfractionated heparin (IV) therapy
- 4. Inadequate home support for outpatient LMWH therapy

IV. <u>Time Frame:</u>

A. 8-24 hour observation

STAMP ED OBSERVATION ADMIT NOTE

Please date and sign each entry		ED OBSERVATION ADMIT NOTE
DATE:		
TIME:		
PROTOCOL: VENOUS THROMBOEMB	OLIC DISEASE//DVT	
Family History: ☐ reviewed and noncontributory	□ other:	
Social History: reviewed and noncontributory	□ other:	
RELEVANT HISTORY/PHYSICAL FINDING	GS (enter values):	
☐ HCG: (+) (-) (N/A)	□ INR:	□ PTT:
☐ Hematocrit:	☐ Platelets:	□ Cr:
☐ Rectal guaiac: Pos Neg		
OBS INTERVENTIONS:		
☐ Oxygen Saturation Monitor	☐ Weight / height	☐ Pharmacy Consult
☐ Cardiac Monitor	☐ Initiate LMWH	☐ Patient Education
☐ Imaging:	☐ Initiate Warfarin	
MEDICAL DECISION MAKING / GOAL OF	OBSERVATION PERIOD:	
HOW OFTEN WILL PATIENT BE EVALUA	TED BY MD/PA: □ Q4H □	Q6H □ Q8H □ Q shift
MORNING PLAN:		
RESIDENT / PA (circle) SIGNATURE:		(PRINTED):
PCP CONTACTED: Y N	NAME:	
THE NEXT SECTION TO BE COMPLET	TED ONLY BY THE ATTEN	DING PHYSICIAN.
☐ I HAVE INTERVIEWED AND EXAMI OBSERVATION ADMISSION AND PLAN RECORD FOR FURTHER DETAIL.		
ATTENDING SIGNATURE:	(PRINTED):	ID #:
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Emergency Department DVT Protocol

RN Initials	5						
WT	Kg (mus	st weigh pation	ent in ED)				
HT:	cm						
RN'	s evaluation of patient's abi	lity to admin	nister LMWH a	t home			
a.	Willingness	Y	N	c.	Able to understand	Y	N
b.	Physical capability	Y	N	d.	Able to redemonstrate	Y	N
Tele	phone number and address	of patient ve	rified				
Veri	fy family support if patient	unable to ad	minister medic	ation alone	,		
	Name & Relationship	р					
Viev	w video (Spanish video avai	lable)					
Give	e patient DVT packet which	includes					
Grvc a.	· ,,,,,		c. B	WH warfa	rin booklet "A Guide to Taking	warfarin"	
b.	· · · · · · · · · · · · · · · · · · ·				C		
Rev	iew "Your Information," on	page 5 of th	e BWH warfar	in educatio	on booklet with patient		
Com	npression stockings size and	apply appro	priate length				
Eno:	xaparin (Lovenox) dose						
War	farin (Coumadin) dose		(5r	ng is recon	nmended starting dose – confirm	with MD if	not 5mg)
					-		
Med	lications reconciled by phar	macist and d	osages checked	d			
MD/PA In	itials:						
Lab	os Checked (HCT, Platelets,	Creatinine,	and INR; Urine	e HCG che	cked if female)		
Pati	ient assessed for contraindic	cations to ant	icoagulation:				
•	GI bleeding: (asked abou	t melena <u>or</u> s	stool guaiac che	ecked)	• Fall Risk		
Prir	nary physician notified and	asked where	anticoagulatio	n managen	nent should occur		
Enst	are follow up visit and bloom	d draw sched	luled:		(1	Date)	
	BIMA, Anticoagulation N						
	•	-	_	_	ement Service: (617) 732-8887		
	Dana Farber Cancer Insti	tute, Anticoa	igulation Mana	gement Ser	rvice: (617) 525-8213		

Brookside Community Health Center, Anticoagulation Management Service: (617) 983-6061



Complete "Your Information," on page 5 of the education booklet: (indication for warfarin, warfarin manager, date and location of next INR with patient)	
If DVT not ruled out in ED, follow-up full vascular study arranged for	_(Site & Date)
Discharge instructions given and potentially serious symptoms (including risk of bleeding) reviewed w	rith patient/family



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PRESENTING COMPLAINT:				
OBSERVATION COURSE:				
☐ Relevant Imaging reviewed		nitiate L	MWH	☐ Patient education
☐ Initiate Warfarin	□ P	harmacy	consult	
☐ Relevant Physical Exam and VS re DISPOSITION:	viewed	I		
DISCHARGE DIAGNOSIS:				
DISCHARGE INSTRUCTIONS GIVEN:	Y	N		
PRIMARY PHYSICIAN CONTACTED:	Y	N	NAME:	
WHAT FOLLOW-UP HAS BEEN ARRANG	ED:			
☐ Follow-up arranged at:				
RESIDENT / PA (circle) SIGNATURE:				(PRINTED)

☐ I HAVE INTERVIEWED AND EXAMI DISCHARGE FROM OBSERVATION		THIS PA	ATIENT AND P	PARTICIPATED IN THE
 □ THE ANTICOAGULATION PATHWA ARRANGEMENTS LISTED ABOVE. □ PLEASE SEE MY DICTATED NOTE 0 	Y WA			I AGREE WITH THE DISCHARGE ATION #:
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FLANK PAIN: PYELONEPHRITIS and UROLITHIASIS

I. Exclusion Criteria:

- A. Suspected sepsis
- B. Severe medical comorbidity.
- C. Known concomitant obstruction and infection
- D. Probability of discharge within 24 hours < 80%

II. Typical OBS Interventions:

- A. Analgesics
- B. Antipyretics
- C. Antiemetics
- D. IV hydration
- E. Antibiotics
- F. Imaging, as indicated
- G. Consultation, as indicated

III. <u>Disposition Criteria:</u>

A. HOME

1. Significant improvement in symptoms

B. HOSPITAL

- 1. Fever (T>101F) at 24 hours
- 2. Deterioration in clinical status
- 3. Obstruction requiring acute intervention

IV. <u>Time Frame:</u>

A. 8-24 hour observation





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TIME:					
PROTOCOL: PYELON	EHRITIS/URO	OLITHIAS	S		
RELEVANT HISTORY/	PHYSICAL FIN	IDINGS:			
Family History: ☐ reviewe	ed and noncontrib	utory			
☐ other:					
Social History: ☐ reviewe	ed and noncontrib	utory			
□ other:					
OBS INTERVENTIONS	:				
☐ Serial exams	☐ Antipyreti	cs	☐ IV hydration	☐ Analgesics	☐ Antibiotics
☐ Antiemetics	☐ Antimicro	bial	☐ Imaging:	☐ Consultation:	☐ Other:
MEDICAL DECISION M	AKING / GOA	L OF OBS	SERVATION:		
HOW OFTEN WILL PA	TIENT BE EVA	LUATED	BY MD/PA: □ C	94H □ Q6H □ Q8H	□ Q shift
MORNING PLAN:					
RESIDENT / PA (circle	SIGNATURE	<u>.</u>		(PRINTED):	
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TIME:						
PRESENTING COMPLAINT:						
OBSERVATION COURSE:						
☐ Antipyretics	☐ IV hydrati	ion		□ Aı	nalgesics	☐ Antibiotics
☐ Improvement in pain	□ Consultat	ion:		□ Re	elevant Physical I	Exam and VS reassessed
DISPOSITION:						
DISCHARGE DIAGNOSIS:						
DISCHARGE INSTRUCTIONS	GIVEN:	Y	N			
PRIMARY PHYSICIAN CONTA	ACTED:	Y	N	NAM	E:	
WHAT FOLLOW-UP HAS BEE	N ARRANGEI	D:				
RESIDENT / PA (circle)	SIGNATURE	:			(PR	INTED):
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☐ I HAVE INTERVIEWED A DISCHARGE FROM OBSIABOVE.						
□ PLEASE SEE MY DICTAT	TED NOTE O	N THIS	PATIE	NT.	DICTATION #	#:
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GENERIC PROTOCOL

I. Global Exclusion Criteria for Management in the Observation Unit:

- A. Patient in restraints
- B. Patient with GCS of < 13 (if new)
- C. Patient with ongoing chest pain or angina equivalent associated with ischemic EKG changes or newly positive cardiac biomarkers
- D. Patient with acute intoxication
- E. Probability of discharge within 24 hours < 80%

Note that patients with exclusions A and D can still be managed in OBS status; same OBS documentation required, but patient does not move to OBS Unit

II. <u>Typical OBS Interventions:</u>

- A. Analgesics
- B. Anti-emetics
- C. Serial exams
- D. Telemetry and oxygen saturation monitoring.
- E. Imaging
- F. Care coordination/social work consultation

III. <u>Disposition Criteria:</u>

A. HOME

1. Treatment and evaluation complete, no indication for inpatient admission

B. HOSPITAL

Ongoing treatment or evaluation after 24 hours of observation

IV. <u>Time Frame:</u>

A. 8-24 hour observation





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TIME:								
CHIEF COMP	LAINT:							
RELEVANT H	IISTORY/PH	YSICAL	FINDING	S:				
Family History:	☐ reviewed a	nd noncon	tributory					
	□ other:							
Social History:	☐ reviewed as	nd noncon	tributory					
	□ other:							
PLAN OF ACT	ΓΙΟΝ:							
MEDICAL DE	CISION MAI	KING / G	OAL OF	OBSERVATION:				
HOW OFTEN	WILL PATIE	ENT BE E	EVALUAT	TED BY MD/PA:	□ Q4H	□ Q6H	□ Q8H	□ Q shift
MORNING PL	AN:							
RESIDENT / F	A (circle)	SIC	NATURE	E:		(PRI	NTED):	
PCP CONTAC	TED:	Y	N	NAME:				
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TIME:							
PRESENTING COMPLAINT:							
OBSERVATION COURSE:							
DISPOSITION:							
DISCHARGE DIAGNOSIS:							
DISCHARGE INSTRUCTIONS	GIVEN:	Y	N				
PRIMARY PHYSICIAN CONT	ACTED:	Y	N	NAMI	Ε:		
WHAT FOLLOW-UP HAS BEE	EN ARRANG	ED:					
RESIDENT / PA (circle) SIGN	ATURE:				(PRII	NTED):	
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☐ I HAVE INTERVIEWED A DISCHARGE FROM OBS ABOVE.	AND EXAMI ERVATION	NED T . I AGI	HIS PA	TIENT A	AND PART E DISCHAR	ICIPATED GE ARRA	IN THE NGEMENTS
□ PLEASE SEE MY DICTA	TED NOTE (ON TH	IS PAT	ENT.	DICTATIO)N#:	
SIGNATURE:			(PRI	NTED):			ID #:



HEADACHE

I. <u>Exclusion Criteria:</u>

- A. Acutely deteriorating neurologic exam or new focal neurological deficit
- B. Suspected meningitis
- C. Hypertensive emergency (diastolic BP >120 with symptoms)

II. <u>Typical OBS Interventions:</u>

- A. Serial exams including vital signs
- B. Analgesics
- C. Imaging, as indicated
- D. Consultation (Neurology, Neurosurgery) as indicated

III. <u>Disposition Criteria:</u>

A. HOME

- 1. Resolution or significant improvement of pain
- 2. No deterioration in clinical course

B. HOSPITAL

- 1. Deterioration in clinical course
- 2. Diagnosis requiring inpatient admission

IV. <u>Time Frame:</u>

A. 8-24 hour observation





Please date and sign each entry ED	OBSERVATION ADM	IT NOTE			
DATE:					
TIME:					
PROTOCOL: HEADACHE					
RELEVANT HISTORY/PHYSICAL FINDI	NGS:				
Family History: ☐ reviewed and noncontributor	ry				
□ other:					
Social History:	ry				
□ other:					
OBS INTERVENTIONS:					
☐ Serial Exams	☐ Imaging:	☐ Other:			
☐ Analgesics	☐ Consultation:				
MEDICAL DECISION MAKING / GOAL O	OF OBSERVATION:				
HOW OFTEN WILL PATIENT BE EVALU	JATED BY MD/PA: □	Q4H			
MORNING PLAN:					
RESIDENT / PA (circle) SIGNATURE:		(PRINTED):			
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THE NEXT SECTION TO BE COMPLETED ONLY BY THE ATTENDING PHYSICIAN.					
☐ I HAVE INTERVIEWED AND EXAMOBSERVATION ADMISSION AND PLARECORD FOR FURTHER DETAIL.		TAND I AGREE WITH THE RIBED ABOVE. PLEASE SEE ED VISIT			
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TIME:						
PRESENTING COMPLAINT:						
OBSERVATION COURSE:						
DISPOSITION:						
DISCHARGE DIAGNOSIS:						
DISCHARGE INSTRUCTIONS GIVEN	N: Y	N				
PRIMARY PHYSICIAN CONTACTED): Y	N	NAM	fE:		
WHAT FOLLOW-UP HAS BEEN ARE	RANGED:					
RESIDENT / PA (circle) SIGNATURE	 ∃:			(PRINTED):		
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THE NEXT SECTION TO BE COMPI	LETED ONL	LY BY TH	IE ATTI	ENDING PHYSICIA	N.	
☐ I HAVE INTERVIEWED AND EDUSCHARGE FROM OBSERVATION						BOVE.
□ PLEASE SEE MY DICTATED N	OTE ON TE	HIS PAT	IENT.	DICTATION #:		
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Metabolic Derangement

I. <u>Exclusion Criteria:</u>

HYPOGLYCEMIA

- A. Intentional over dosage of hypoglycemic medications
- B. Intake of large amounts of long acting oral hypoglycemic
- C. Altered mental status in spite of glucose administration
- D. Serious precipitating cause

HYPERGLYCEMIA:

- A. Ketoacidosis; pH <7.30 or total $C0_2$ < 18 or anion gap >15
- B. Hyperosmotic non-ketotic coma
- C. Glucose > 600mg/dl
- D. Serious precipitating cause

HYPOKALEMIA:

- A. K + < 2.5mEq/dl
- B. Cardiac dysrhythmia
- C. Serious precipitating cause

II. <u>Typical OBS Interventions:</u>

- A. Serial exams and vital signs
- B. IV hydration
- C. Serial labs
- D. Administration of glucose
- E. K + administration
- F. Diabetic counseling
- G. Insulin administration

III. <u>Disposition Criteria:</u>



HYPOGLYCEMIA

A. HOME

- 1. Complete resolution of symptoms
- 2. Capable adult supervision
- 3. Blood sugars over 80mg/dl
- 4. Precipitating factor(s) addressed
- 5. Taking PO's

HYPERGLYCEMIA

A. HOME

- 1. Resolution of symptoms
- 2. Precipitating factor(s) addressed
- 3. Taking PO's

B. HOSPITAL

- 1. Deterioration of clinical status
- 2. Persistent hyperglycemia with widening anion gap

HYPOKALEMIA

A. HOME

- 1. K+>3.5
- 2. Taking PO's

B. HOSPITAL

- 1. Deterioration of clinical signs
- 2. Inability to adequately treat precipitating factors
- 3. Cardiac dysrhythmia

IV. <u>Time Frame:</u>

A. 8-24 hour observation





Please date and sign each entry ED OBSERVATION ADMIT NOTE
DATE:
TIME:
PROTOCOL: METABOLIC DERANGEMENT IF DIABETES: □ TYPE 1 □ TYPE 2
RELEVANT HISTORY/PHYSICAL FINDINGS:
Family History: □ reviewed and noncontributory
□ other:
Social History: reviewed and noncontributory
□ other:
OBS INTERVENTIONS:
☐ Serial exams ☐ Hydration ☐ Electrolytes Repletion
☐ Blood Glucose Monitoring ☐ Diabetic Counseling ☐ Other:
☐ Insulin Sliding Scale
MEDICAL DECISION MAKING / GOAL OF OBSERVATION PERIOD:
HOW OFTEN WILL PATIENT BE EVALUATED BY MD/PA: □ Q4H □ Q6H □ Q8H □ Q shift
MORNING PLAN:
RESIDENT / PA (circle) SIGNATURE: (PRINTED):
PCP CONTACTED: Y N NAME:

THE NEXT SECTION TO BE COMPLETED ONLY BY THE ATTENDING PHYSICIAN.
☐ I HAVE INTERVIEWED AND EXAMINED THIS PATIENT AND I AGREE WITH THE OBSERVATION ADMISSION AND PLAN OF CARE AS DESCRIBED ABOVE. PLEASE SEE ED VISIT RECORD FOR FURTHER DETAIL.
ATTENDING SIGNATURE: (PRINTED): ID#:





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DATE:					
TIME:					
PRESENTING COMPLAINT:					
OBSERVATION COURSE:					
DISPOSITION:					
DISCHARGE DIAGNOSIS:					
DISCHARGE INSTRUCTIONS GIVEN	I: Y	N			
PRIMARY PHYSICIAN CONTACTED): Y	N NA	ME:		
WHAT FOLLOW-UP HAS BEEN ARR	ANGED:				
RESIDENT / PA (circle) SIGNATURE	B:		(PRINTED):		
**************************************					**
THE NEXT SECTION TO BE COMPL ☐ I HAVE INTERVIEWED AND EX					
DISCHARGE FROM OBSERVATIO	N. I AGRE	E WITH THE	DISCHARGE ARRA	NGEMENTS ABOVE.	
□ PLEASE SEE MY DICTATED NO	OTE ON TH	HIS PATIENT.	DICTATION #:		
ATTENDING SIGNATURE		(PRINTED):		ID #:	
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PNEUMONIA

- I. Step 1) Calculate the PORT score at http://www.mdcalc.com/
 - Step 2) Note exclusion criteria:
 - High suspicion of PE
 - High suspicion of TB
 - Known HIV
 - Step 3) Consider alternative diagnoses:
 - Pulmonary infarction
 - CHF
 - Hypersensitivity
 - Step 4) Disposition by PORT score class:

Class I (without hypoxemia) →HOME

- Antibiotic choice 1: Azithromycin 500 mg PO day 1, then 250 mg days 2-5
- Antibiotic choice 2: Doxycycline 100 mg PO twice daily for 7-10 days

Class II (under 60y without hypoxemia) →HOME

- Anitibiotic choice 1: Amoxicillin 1 gram PO TID for 7-10 days + Azithromycin 500 mg x1, then 250 mg days 2-5
- Antibiotic choice 2: Respiratroy quinolone (Levofloxacin 750 mg PO daily for 7 days or Moxifloxacin 400 mg PO daily for 7 days)

<u>Class II (>59y or hypoxemia)</u> →ED OBS or HOME

- Antibiotic choice 1: Ceftriaxone 1 gram IV + Azithromycin 500 mg PO
- Antibiotic choice 2: Levofloxacin 750 mg PO

If safe for discharge home after OBS stay:

- Antibiotic choice 1: Amoxicillin 1 gram PO TID for 6-9 days + Azithromycin 250 mg PO for 4 days
- Antibiotic choice 2: Levofloxacin 750 mg PO daily for 6 days or Moxifloxacin 400 mg PO daily for 6 days

Class III →ED OBS

Treat as above for Class II >59 or hypoxemia



<u>Class IV</u> →Admit to hospital using pneumonia template for antibiotic choices

Class V \rightarrow Admit to ICU using pneumonia template for antibiotic choices

II. Typical OBS Interventions:

- A. IV Antibiotics
- B. O₂ % SAT Monitoring
- C. Supplemental O₂, as indicated
- D. Hydration
- E. Bronchodilator treatments, as indicated

III. <u>Disposition Criteria:</u>

A. HOME

1. Improvement in clinical condition

B. **HOSPITAL**

- 1. Symptoms unimproved in 24 hours
- 2. Deterioration in clinical status
- 3. O₂ % SAT <90 on RA after 24 hours (unless baseline is this value)

IV. Time frame

A. 8-24 hour observation



Please date and sign each entry	ED OBSERVATION ADMIT NOTE	
DATE:		
TIME:		
PROTOCOL: PNEUMONIA		
RELEVANT HISTORY/PHYSICAL FI	NDINGS:	
Family History: □ reviewed and noncontri	butory	
□ other:		
Social History:	butory	
□ other:		
OBS INTERVENTIONS:		
☐ Antibiotics	☐ O ₂ % Sat Monitoring ☐ Bronchodila	ator Treatments
☐ Supplemental Oxygen	☐ Hydration ☐ Other:	
MEDICAL DECISION MAKING / GO.	AL OF OBSERVATION PERIOD:	
HOW OFTEN WILL PATIENT BE EV	ALUATED BY MD/PA: □ Q4H □ Q6H	□ Q8H □ Q shift
MORNING PLAN:		
RESIDENT / PA (circle) SIGNA	ATURE: (PRIN	TED):
PCP CONTACTED: Y	N NAME:	
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THE NEXT SECTION TO BE COM	MPLETED ONLY BY THE ATTENDING I	PHYSICIAN.
	EXAMINED THIS PATIENT AND I AGREE	
OBSERVATION ADMISSION AND RECORD FOR FURTHER DETAIL.	PLAN OF CARE AS DESCRIBED ABOVE.	PLEASE SEE ED VISIT
ATTENDING SIGNATURE:	(PRINTED):	ID #:



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ED PROGRESS NOTE





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PRESENTING COMPLAINT:						
OBSERVATION COURSE:						
DISPOSITION:						
DISCHARGE DIAGNOSIS:						
DISCHARGE INSTRUCTIONS GIVE	N: Y	N				
PRIMARY PHYSICIAN CONTACTEI	D: Y	N	NAMI	E:		
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ATTENDING SIGNATURE:	<u>(I</u>	PRINTEI	O):		ID #:	
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PSYCHIATRIC EMERGENCY

I. <u>Exclusion Criteria for Transfer to Observation Unit:</u>

- A. Demonstrating active violent or disruptive behavior
- B. Requiring physical restraints
- C. Patient not awake and alert
- D. Probability of discharge within 24 hours < 80%

II. Typical OBS Interventions:

- A. Completion of medical clearance and psychiatric evaluation
- B. Discharge to safe environment in the community
- C. Bed search for transfer to psychiatric facility or admission to hospital
- D. Trial use of medication

III. <u>Disposition Criteria:</u>

A. HOME

- Safe discharge plan established
- 2. Completion of diagnostic evaluation

B. **HOSPITAL**

1. Patient under Section 12 or requiring hospitalization for any reason with no imminent transfer to Psychiatric hospital after 24 hours of observation

IV. Time Frame:

A. 8-24 hour observation





Please date and sign each entry	ED OB	SERVATION ADMIT NOTE
DATE:		
TIME:		
PROTOCOL: PSYCHIATRIC EMERGEN	ICY	
RELEVANT HISTORY/PHYSICAL FINDIN	NGS:	
Family History: ☐ reviewed and no	ncontributory	
□ other:		
Social History: reviewed and not	ncontributory	
□ other:		
OBS INTERVENTIONS:		
☐ Psychiatry consultation (p13088)	☐ Social Work consultation	☐ Sitter
☐ Administer medications	☐ Complete medical clearance	
MEDICAL DECISION MANUAL (COAL O	E ODGEDIA TION DEDIOD	
MEDICAL DECISION MAKING / GOAL O	F OBSERVATION PERIOD:	
HOW OFTEN WILL PATIENT BE EVALUA	ATED BY MD/PA: □ Q4H □ Q	6H □ Q8H □ Q shift
MORNING PLAN:		
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PCP CONTACTED: Y N ***********************************	NAME: ************	********
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Please date and sign each entry ED OBSERVATION DISCHARGE NOTE	
DATE:	
TIME:	
PRESENTING COMPLAINT:	
OBSERVATION COURSE:	
DISPOSITION:	
DISCHARGE DIAGNOSIS:	
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PRIMARY PHYSICIAN CONTACTED: Y N NAME:	
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RESIDENT / PA (circle) SIGNATURE: (PRINTED):	
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☐ PLEASE SEE MY DICTATED NOTE ON THIS PATIENT. DICTATION #:	
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SOCIAL INTERVENTIONS

I. Exclusion Criteria:

- A. Medicare (or other) requirement for inpatient admission prior to placement
- B. Probability of discharge within 24 hours < 80%

II. Typical OBS Interventions:

- A. Serial exams
- B. Care Coordination consultation
- C. Social Work consultation
- D. Physical Therapy evaluation

III. <u>Disposition Criteria:</u>

A. HOME

1. Safe discharge plan for home established

B. HOSPITAL

- 1. Inability to find appropriate placement after 24 hours of observation
- 2. Development of clinical indication for inpatient hospitalization

IV. Time Frame:

A. 8-24 hour observation

NOT A PART OF THE MEDICAL RECORD



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DATE:		
TIME:		
PROTOCOL: SOCIAL INTERVENTIONS		
RELEVANT HISTORY/PHYSICAL FINDINGS:		
Family History: □ reviewed and noncontributory □	other:	
Social History: □ reviewed and noncontributory □	other:	
OBS INTERVENTIONS:		
☐ ED Care Coordination (x56412) ☐ Ph	ysical Therapy	☐ Medical clearance
☐ Social Work (x24623)		
MEDICAL DECISION MAKING / GOAL OF OB	SERVATION PE	ERIOD:
HOW OFTEN WILL PATIENT BE EVALUATED	D BY MD/PA:	□ Q4H □ Q6H □ Q8H □ Q shift
MORNING PLAN:		
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UNEXPLAINED SYNCOPE AND NEAR SYNCOPE

I. <u>Exclusion Criteria:</u>

- A. Acute confusional state or intoxication
- B. New focal neurologic deficit
- C. Significantly abnormal or unstable vital signs
- D. History of or highly suspected ventricular arrhythmia (i.e., EF ≤ 35%)
- E. Presence of cardiac device with dysfunction
- F. Probability of discharge home within 24 hours < 80%

II. <u>Typical OBS Interventions:</u>

- A. Serial vital signs (please obtain and document orthostatic vitals prior to Obs admission)
- B. IV hydration, if indicated
- C. Telemetry
- D. Serial cardiac biomarkers, if indicated
- E. Cardiac stress testing, at the discretion of the attending
- F. Echocardiogram, at the discretion of the attending
- G. Hold blood pressure medications, if appropriate

III. <u>Disposition Criteria:</u>

A. HOME

- 1. Benign observation course
- 2. Stable vital signs
- 3. Appropriate home environment

B. **HOSPITAL**

- 1. Any diagnosis requiring inpatient admission
- 2. Recurrent syncope or near syncope
- 3. Unable to be safely discharged home because of functional or social reasons

IV. <u>Time Frame:</u>

A. 8-24 hour observation

NOT A PART OF THE MEDICAL RECORD



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Please date and sign each entry	ED OBSERVATION ADMIT NOTE
DATE:	
TIME:	
PROTOCOL: SYNCOPE	
RELEVANT HISTORY/PHYSICAL FINDINGS:	
Family History: □ reviewed and noncontributory	
□ other:	
Social History: reviewed and noncontributory	
□ other:	
OBS INTERVENTIONS:	
☐ Serial exams ☐ Hydration	☐ Echocardiogram ☐ 2 Sets of Cardiac markers
☐ Telemetry ☐ Cardiac Stress Te	est
MEDICAL DECISION MAKING / GOAL OF OBS	ERVATION PERIOD:
HOW OFTEN WILL PATIENT BE EVALUATED	BY MD/PA: □ Q4H □ Q6H □ Q8H □ Q shift
MORNING PLAN:	
RESIDENT / PA (circle) SIGNATURE:	(PRINTED):
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TRANSFUSION

I. Exclusion Criteria:

- A. Acute, active bleeding
- B. History of severe transfusion reaction
- C. Fever or unstable vital signs
- D. Probability of discharge within 24 hours < 80%

II. Typical OBS Interventions:

- A. Transfuse blood products
- B. Telemetry and oxygen saturation monitoring
- C. Monitor for transfusion reactions
- D. Serial exams
- E. Repeat hematocrit, at discretion of ED attending

III. <u>Disposition Criteria:</u>

A. HOME

- 1. Transfusion complete
- 2. Target hematocrit reached

B. HOSPITAL

- 1. New fever
- 2. Deterioration in clinical status
- 3. Adverse reaction
- 4. Renewed bleeding

IV. Time Frame:

A. 8-24 hour observation





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PROTOCOL: TRANSFUSION	
RELEVANT HISTORY/PHYSICAL FINDINGS:	
Family History: □ reviewed and noncontributory	
□ other:	
Social History: reviewed and noncontributory	
□ other:	
OBS INTERVENTIONS:	
☐ Serial exams ☐ Transfuse	☐ Post-Transfusion hematocrit ☐ Other:
MEDICAL DECISION MAKING / GOAL OF OB	SSERVATION PERIOD:
HOW OFTEN WILL PATIENT BY EVALUATE	D BY MD/PA: □ Q4H □ Q6H □ Q8H □ Q shift
MORNING PLAN:	
RESIDENT / PA (circle) SIGNATURE:	(PRINTED):
PCP CONTACTED: Y N	NAME:

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TRANSIENT NEUROLOGIC EVENT

I. <u>Exclusion Criteria:</u>

- A. Suspected acute CVA
- B. Hypertensive crisis (diastolic BP >120)
- C. Concern for worsening neurological exam
- D. Newly depressed level of consciousness
- E. Probability of discharge home within 24 hours < 80%

II. Typical OBS Interventions:

- A. CT/MRI, as indicated
- B. Neurology/neurosurgery consultation, as indicated
- C. Telemetry
- D. Echocardiogram, if indicated
- E. Neuro checks every four hours
- F. Monitor vital signs
- G. Antiplatelet therapy, if indicated

III. Disposition Criteria:

A. HOME

- 1. Stable or improved neurologic exam
- 2. Initial work-up complete

B. HOSPITAL

- 1. Deterioration in clinical/neurological exam
- Diagnosis requiring inpatient admission

IV. Time Frame:

A. 8-24 hour observation

NOT A PART OF THE MEDICAL RECORD





Please date and sign each entry	ED OBSERVATION ADMIT NOTE
DATE:	
TIME:	
PROTOCOL: TRANSIENT NEUROLOGIC EVENT	
RELEVANT HISTORY/PHYSICAL FINDINGS:	
Family History: reviewed and noncontributory	
□ other:	
Social History:	
□ other:	
OBS INTERVENTIONS:	
☐ Neuro checks q4h ☐ ASA	☐ Imaging:
☐ Telemetry ☐ Consultation:	☐ Other:
MEDICAL DECISION MAKING / GOAL OF OBSERVATIO	N PERIOD:
HOW OFTEN WILL PATIENT BE EVALUATED BY MD/PA	A: □ Q4H □ Q6H □ Q8H □ Q shift
MORNING PLAN:	
RESIDENT / PA (circle) SIGNATURE:	(PRINTED):
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PRESENTING COMPLAINT:					
OBSERVATION COURSE:					
☐ Imaging reviewed				☐ Consultations:	
☐ Relevant Physical Exam and VS review	/ed				
DISPOSITION:					
DISCHARGE DIAGNOSIS:					
DISCHARGE INSTRUCTIONS GIVEN:	Y	N			
PRIMARY PHYSICIAN CONTACTED:	Y	N	NAMI	3:	
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