THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Consult Courtesy Guidance Document

General Courtesies:

I. Please see the patient (in person or over tele-medicine) before putting in a consult.
II. Please plan to be the patient's primary physician for the next 30-60 minutes before putting in a consult. If a situation arises in which a consult needs to be placed at the end of your shift, please sign out the team's reasoning and needs/hopes/expectations for the consultant specifically and explicitly and the callback number for yourself and the covering physician.
III. Please page the team with a callback number (per medical center policy) before placing an Urgent or STAT consult
IV. If you need to place a routine consult, please include that information in your handoff to the next provider rather than entering the routine consult overnight.
V. Please include your specific reason for consultation in the consult order. *This is especially true for teams who take in house call (for ex, general surgery is available 24/7 for emergencies). If you do not have a specific question or would like to "get the consulting team on board," please use the 'questions pager/call number' to discuss with the consulting team directly before ordering the consult.
VI. Please put a cellphone number, Cisco phone number, or your team-room's office phone number in the contact number space on the consult order if possible. Please avoid putting the team's name, a pager number, a temporary phone number at which you will not be for less than 30 minutes, or any other non-specific contact information.
VII. When placing a consult for an admitted patient that is routine in nature, an H&P should be in the chart prior to placing the consult request. If, however, you are not able to enter the H&P prior to placing the consult, then please ensure that you know the patient's history prior to placing the consult.
VIII. For patients transferred from an OSH, please ensure that images are pushed to Ambra prior to placing consult (unless there is an urgency to the consult). Ideally, these images would also be nominated to PACS as soon as possible.
IX. For consults regarding procedures, please document whether anticoagulation can be held, last dose of anticoagulation, and who is the surrogate decision maker if the patient lacks capacity.

Consult Team: Inpatient Allergy and Immunology

Program/Department: Internal Medicine

Stat Pager: Fellow on-call
Pager to call if inpatient teams have general questions: Fellow on-call

Courtesies:

- If concerned about a patient with SLE with a flare, please obtain CBC, CMP, C3/C4, ds DNA, and urinalysis.
- If specific consult question is in regard to a positive lab result (ANA, ANCA, etc.), state why this test was initially ordered.
- If concerned about flare of autoimmune, inflammatory disease, we will likely order ESR and CRP, so best to have that ready

- For concern of new GCA, recommend Ophthalmology consultation for inpatient temporal artery biopsy
- For concern for pulmonary-renal syndrome due to ANCA vasculitis that may need remission induction with cyclophosphamide or rituximab, please obtain chronic hepatitis panel and Quantiferon Gold
- For concern for lupus nephritis flare, please consult Renal as well
- For concern for antiphospholipid antibody syndrome, please consult Hematology-Oncology as well
- If consulting for arthrocentesis or intra-articular glucocorticoid injection, please obtain XR of the affected joint if none recently performed and available for review

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Consult Team: Anesthesiology/Acute Pain

Program/Department: Anesthesiology

E1 (PGY4 on call after 3pm) Phone: 64575

Acute Pain Consult Pager: 8095

Pre-Op Resident Phone: 36820

Courtesies:

- Anesthesia consults are only required for patients in need of a cardiac anesthesiologist. Specific indications for a cardiac anesthesiologist to be involved in a patient's care include the following:
    - Patients who have mechanical support such as ventricular assist devices (VADs) or extracorporeal life support (ECLS)
    - Patients with complex congenital heart disease
    - Patients undergoing procedures that require cardiopulmonary bypass
    - Patients undergoing procedures that require continuous intraoperative transesophageal echocardiography (TEE)
    - Patients who have severe pulmonary hypertension who are currently receiving intravenous prostacyclins as treatment
    - Of note, severe valvular disease is NOT an indication for a cardiac anesthesiologist to be involved in a patient's care

- Questions regarding preoperative optimization prior to surgery for inpatient surgery scheduled for the following day can be directed to the pre-operative resident. This resident is responsible for evaluating inpatients scheduled for surgery the following day.

- Acute pain consults should be placed for patients who may benefit from procedural intervention addressing an acute process. For example, placement of an epidural or perineural catheter. Medication management consults can be placed to the chronic pain team or palliative medicine if appropriate.

- Routine consults placed after 3pm will be seen the following day. Please page 8095 with any urgent matters.

Consult Team: General Cardiology

Program/Department: Cardiology/Internal Medicine

Ross Code Blue Pager: 6074

Courtesies:

- Please obtain ECG at time of consult.
  - From 7 AM – 5 PM on weekdays : Ross/ED/CDU/Harding/Dodd #9210
  - 7AM-5PM on weekdays: UH/James/BASH #5551.
  - After hours please page #9999 regardless of patient location.
- Non-urgent consults placed after hours will be seen the following day.
- Routine consults placed on the weekend before 10:00 AM will be seen that day. Routine consults placed after 10:00 AM will be seen by the following day. Please page #9999 for any Urgent or STAT consults placed after hours or on the weekend.
- For questions about need for ICD or ablation of arrhythmia, please page EP directly at #4431. If unsure whether a consult is appropriate for EP or general cardiology, we are happy to help triage.
- Please refer to the "Acute Coronary Syndrome (ACS) Initial Evaluation and Management" for guidance regarding evaluating ACS with the new high sensitivity troponin assay. This document can be found on OneSource by searching "Acute Coronary Syndrome" or "high sensitivity troponin".

Consult Team: Dermatology

Program/Department: Internal Medicine

STAT Pager: 6537

Questions Pager: 6537

Courtesies:

- Please ask a specific question in the reason for consult
- For lesions/rashes that are chronic and indolent appearing, please consider an outpatient referral
- Dermatology consult team typically rounds with the attending in the afternoon. The dermatology team will contact the consulting team with official recommendations as soon as possible.
- Please refrain from placing a consult on the day of discharge as this will likely cause delay in patient discharge.
- For patients who are being followed by OSU Dermatology outpatient for chronic issues – if the reason for admission is not primarily a dermatology issue – consider referencing the most recent

dermatology outpatient note for current recommendations rather than placing an inpatient consult.
- Please place high quality, in focus photos in the chart either in a progress note or in the scanned media tab, that demonstrate all areas of cutaneous and mucosal involvement prior to placing the inpatient dermatology consult.
- Please leave a call back number on the consult order, not just the pager number.
- For rashes with concern for drug eruption, please have the primary team document a complete drug history.
- Dermatology takes home call. Please be courteous to place routine dermatology consults only during the hours of 8 am – 8 pm as the page with the consult will automatically go through as soon as the order is placed in IHIS.

Consult Team: Electrophysiology

Program/Department: Electrophysiology/Cardiology/Internal Medicine

STAT Pager: 4431

Questions Pager: 4431

Courtesies:

- Please obtain ECG at time of consult.
- Please obtain an echocardiogram at the time of consult if no ECHO has been performed within the past 12 months.
- If you are consulting for an arrhythmia noted on telemetry please print tracings and place them in chart, or scan into IHIS. Note that telemetry tracings will not be able to be retrieved if a patient changes location within the hospital.
- If you are consulting regarding a device (pacemaker or ICD) please order a device interrogation at the time of consult. The name of the order is...

All EP procedures require COVID PCR testing prior. Please order at the time of consult if you suspect an EP procedure will be required.

Consult Team: Inpatient Endocrinology, Diabetes, and Metabolism

Program/Department: Endocrinology, Diabetes, and Metabolism

Stat Pager: Please see WebXchange for on-call Endocrine Fellow

Questions Pager: to call if inpatient teams have general questions: Please see WebXchange for on-call Endocrine Fellow

Consult Courtesy Guidance Document

Courtesies:

- Please contact correct team for questions regarding diabetes consults. Review most recent progress note, if note authored by fellow contact team 1. If note authored by CNP, contact team 2. Team 1 (fellows) generally covers diabetes consults in the James, floor 12 and above, and Harding hospital.
- For hypoglycemia, please utilize proper definitions (glucose <70mg/dl in patients with diabetes, glucose <55mg/dl in patients with no history of diabetes), and verify hypoglycemic point of care capillary readings with serum glucose blood draw prior to giving dextrose/juice to treat low glucose. Consider checking TSH, free T4, and AM cortisol for patients experiencing true hypoglycemia.
- For hypocalcemia, please ensure calcium is corrected for albumin levels. If true hypocalcemia, please check intact PTH, and vitamin D levels (25 hydroxy and 1-25 hydroxy)
- For adrenal insufficiency evaluation prior to initiation of glucocorticoid therapy, please draw cortisol (ideally at 8am). Consider ordering cosyntropin stimulation test (order set available). If patient will be started on glucocorticoids in near future, please draw random cortisol ASAP, prior to steroid administration.
- For severe hypothyroidism, please check random cortisol level (if able, please add on to labs collected around 8am). Please do complete physical exam, including mental status evaluation, reflexes, and noting presence of periorbital or lower extremity edema prior to placing consult
- For IV levothyroxine request consults, verify patient will not have enteral access for medications for >5 days. Please check free T4 level prior to placing consult
- For hypothyroidism in patient receiving continuous tube feeds, please verify tube feeds are being held for one hour before and after levothyroxine dose.
- For central diabetes insipidus evaluation, please trend sodium, urine osmolality, urine specific gravity, and verify nursing is documenting strict intake/output information in EMR
- Thyroid biopsies are not completed in inpatient setting. If a patient requires thyroid biopsy, please place ambulatory referral to endocrinology for “thyroid nodule biopsy” upon discharge from hospital
- For insulin pump consults, please be able to tell consultant if pump is currently on and in use, and be able to comment on patients current mental status (ability to run their pump)

Consult Team: ENT/Otolaryngology

Program/Department: ENT/Otolaryngology

Stat Pager: per WebXchange

Questions Pager: per WebXchange

Courtesies:

- Always provide a primary team callback number (NOT just pager #) to facilitate communication and patient care
- Airway/respiratory distress:
  - Page our team ASAP with callback number
  - If patient requires immediate intubation with history of difficult airway:
    - Activate DART response team (dial 63133) and bring DART airway cart to the room immediately
- Epistaxis: First spray Afrin (vasoconstrictor), hold uninterrupted nasal pressure x 10-15 minutes, control blood pressure, and address coagulopathy
- How to contact the appropriate resident:
  - Head and neck cancer (only for established outpatient patients) -> James consults pager
  - Trach -> Trach consults pager
    - If trach was placed by another OSU service, that team must be consulted first
    - Obtain information about existing trach (date of placement, size of trach including whether cuffed/cuffless, etc.)
  - All other consults (including new/suspected head and neck cancer patients) -> ED/UH/Ross consults pager

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Consult Team: Gastroenterology

Program/Department: Gastroenterology/Internal Medicine

Stat Pager: per WebXchange

Questions Pager: per WebXchange

Courtesies:

- Please distinguish melena from "dark stools." GI typically does not need to evaluate "dark stools." There is no indication for inpatient fecal occult blood testing.
- For anemia without overt bleeding, full anemia workup (iron studies, reticulocyte count, others as indicated) should be resulted prior to consultation with GI.
- For PEG, team should discuss risks/benefits with the patient/surrogate prior to GI consultation, and document results of this conversation in the progress note. Hx of abdominal surgery should be included in progress notes. If jejunal feeding is needed please consult with IR or surgery for direct jejunal feeding tube ("PEJ").
- Chronic GI symptoms without electrolyte abnormalities or imaging/endoscopic abnormalities or with prior extensive evaluation may be seen as outpatient. For example, gastroparesis may be effectively managed by clear liquid diet, inpatient treatment with erythromycin or metoclopramide, and outpatient follow up.
- For acute diarrhea, infectious studies and CRP should be resulted prior to GI consultation.

- Outpatient procedures should be rescheduled by the primary team's PCRM if patients are admitted for issues unrelated to the procedure (i.e., decompensated heart failure scheduled for outpatient screening colonoscopy)
- For colonoscopy, may continue GoLytely/Miralax past midnight if stools are not yet clear. "Clear" means yellow/green liquid stools without sediment. Anesthesia requires 6 hours without liquids so it is better to continue the preparation in the early morning than to delay/reschedule the case.

Consult Team: Geriatrics

Program/Department: Internal Medicine

Stat Pager: per WebXchange

Questions Pager: per WebXchange

Courtesies:

For Delirium:

- Use Confusion Assessment Method (CAM) tool to identify and recognize delirium.
- There is a guideline "Inpatient Management and Prevention of Delirium" on OneSource
- Always be mindful of hypoactive delirium which tends to be unrecognized during initial hospital stay.
- Always try non pharmacologic interventions for prevention and management of delirium which include: redirect/reorient/reassure patient frequently, avoid restraints and instead utilize sitter as needed for safety, early mobilization as medically appropriate, have patient use glasses and hearing aids, use familiar objects (family photos and items from home), sleep hygiene, limit nighttime care to promote sleep/wake cycle, hydrate and encourage PO intake when medically appropriate, minimize/camouflage lines and tethers as able, minimize narcotics as long as pain is adequately controlled, avoid benzos and anticholinergic medications.
- Melatonin at night can help with restoring sleep cycle.
- Avoid using benzodiazepines for agitation in elderly. Possible exceptions are treatment of alcohol or benzodiazepine withdrawal.
- Common causes of delirium include dehydration, constipation, urinary retention, polypharmacy, infections and electrolytes imbalances. Optimize bowel regimen if patient is constipated. Early identify and manage urinary retention. Treat underlying infection.
- Delirium can sometimes resolve within hours to days. In other cases, it takes weeks or even months to fully resolve.
- Rule out infectious causes: Obtain UA with reflex culture, culture any central line, consider blood cultures if febrile
- Contact family, home nurses, or SNF/ALF to obtain the patient's baseline mental status
- Consider CBC, CMP for electrolyte abnormalities or reversible causes
- Carefully review each medication

  - Identify any medications recently discontinued, started, or changes in dosages or frequency
  - Then use the BEERS list to review the patient's medication list

For Polypharmacy

- Carefully review each medication
- Identify any medications recently discontinued, started, or changes in dosages or frequency
- Then use the BEERS list to review the patient's medication list

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Consult Team: Hematology

Program/Department: Division of Hematology/Internal Medicine

Stat Pager: IM consult serv Hematology (in WebXchange)

Questions Pager: IM consult serv Hematology (in WebXchange)

Courtesies:

- Anemia Consults: please order reticulocyte count, ferritin, iron panel, B12, and folate. If concerns for hemolysis, please order haptoglobin, LDH, and total bilirubin (with direct bilirubin)
- Thrombocytopenia Consults: if concerned for DIC or other TMA, please order PT/INR, PTT, and fibrinogen in addition to hemolysis labs above. If concerned for HITT, please calculate a 4T score
- DVT/PE Consults: please do not initiate thrombophilia testing while inpatient when patient has an acute thrombus

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Consult Team: Hepatology

Program/Department: Hepatology/Internal Medicine

Pager for Hepatology: Please refer to the IM Consult Serv Hepatobiliary on WebXchange

Pager for Pancreatic/Biliary and IBD: Please refer to the IM Consult Serv Gastroenterology on WebXchange

Courtesies:

- MELD labs (Na, Cr, TBili, INR) and some imaging of the liver (RUQ US) should be performed prior to Hepatology consultation. If imaging completed at OSH, please obtain images and report.
- For hepatic encephalopathy consults, paracentesis should be completed (or investigated for suitable location), lactulose prescribed, other infectious sources, and medication use evaluated prior to/in addition to Hepatology consultation.

- New diagnosis of hepatitis C (HCV) does not need to be seen inpatient (treatment cannot be started inpatient) – these patients should follow up in outpatient liver clinic after discharge. Place an order for ambulatory referral to Hepatology.
- Outpatient procedures should be rescheduled by the primary team's PCRM if patients are admitted for issues unrelated to the procedure (i.e., decompensated heart failure scheduled for outpatient screening colonoscopy)
- For colonoscopy, may continue GoLytely/Miralax past midnight if stools are not yet clear. "Clear" means yellow/green liquid stools without sediment. Anesthesia requires 6 hours without liquids so it is better to continue the preparation in the early morning than to delay/reschedule the case.

Consult team: Inpatient Infectious Disease

Program/Department: Internal Medicine

STAT pager: 6818 (First Call On Call Fellow)

Questions Pager for a Patient ID is following: Please call the on call fellow for the team following the patient. The ID team should be listed at the end of the ID notes. If no team is listed, please page the on call fellow at 6818.

Questions Pager for a Patient ID is NOT following: 6818 (First Call On Call Fellow)

Courtesies:

- For patients transferred from an outside hospital, please have a copy of culture results if possible uploaded to patient's chart in media tab for review.
- Please know if the patient has had any multi-drug resistant (MDR) organisms in the past.
- Know their prior infectious disease history.
- Obtain a history for recent antibiotics or antiviral drugs, dosages, and frequency.
- Determine the risk factors that patient has for an infection.
- If suspicion for a respiratory infection, please obtain sputum culture.

Consult team: Inpatient Nephrology

Program/Department: Internal Medicine

STAT pager: from 5pm to 7am: page night float fellow (any WebX pager)

STAT pager: For 7am - 5pm:

- If ESRD, page on-call ESRD (NP/attending service, very rarely has fellow coverage)
- If ICU, page on-call James/ICU fellow for new/STAT day time consult
- If UH/Dodd/Harding, page on-call General fellow (routine or STAT)

- If Ross, page on-call Ross fellow/attending (also rarely covered by Fellow)
- If Transplant, *page on-call attending before 5pm* (fellow coverage only overnight)
    - there is a 10R and non-10R attending on WebX for page (do not IHIS chat)
- On weekdays, please check Neph notes to see if patient is James 1, 2, 3 service. James 1 is the ONLY fellow service; James 2-3 are attending only, so please page them.

Questions Pager:

Courtesies:

- UA, UPCR, Microalbumin/Cr and Renal US/CT (some type of kidney image)
- Hyponatremia: urine lytes (Na, K, and Cl) Ur Osmo daily (helps to have a few days trend if you try to treat before you consult)
- Hypernatremia: try to calc and supplement *free water* deficit first
- Hyperkalemia: obtain urine lytes to evaluation TTKG (should be off supplementation for 24 hours preferably)
- Metabolic Acidosis: obtain VBG and UA/urine pH, evaluate for AGMA vs. NAGMA and work up AGMA causes (lactic, BHBT, osmo gap, EtOH/methanol, etc)
- Weekends: usually cross-coverage by off-service fellows so please clarify weekend plans/DC planning questions Friday with main service providers.

Consult team: Neurology and Neurovascular

Program/Department: Neurology

Courtesies:

STAT pager: per WebXchange

Stroke phone: 60700

Questions Pager:

- For encephalopathy consults, please consider checking ammonia, infectious workup, TSH, B12, and folate prior to or when consulting, as well as HIV and RPR if clinically indicated
- For Guillain Barre and Myasthenia Gravis consults, please obtain baseline respiratory parameters of Negative Inspiratory Force and Vital Capacity and have them documented in an easily accessible progress note.
- For syncope/dizziness consults, please obtain orthostatic vitals (specifically both HR and BP with 3-minute waiting period after changing positions between each measurement) and have them documented in an easily accessible progress note
- When placing a stroke (neurovascular) consult, please specify last known normal (if known) and whether patient is on anticoagulation. If there is concern for an acute stroke, please call Cisco phone 60700 in addition to putting in a STAT consult.

- For consults for concern for subclinical seizures, consider consulting neurology first to evaluate for need for continuous EEG prior to ordering routine EEG
- For seizure consults, please indicate names and doses of anti-epileptic drugs administered during hospitalization
- For headache consults, consider utilizing clinical practice guidelines for "Headache: Acute - Inpatient / Emergency Department Management", and please provide information to consult team about which of these treatments have been given

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Consult Team: Neurosurgery

Program/Department: Neurological Surgery

Stat Pager: 9540

Questions Pager:

Courtesies:

- Prior to placing consult, please conduct a basic neurological examination. This includes:
    - Orientation
    - Speech
    - Pupil light response
    - Strength/sensation in bilateral upper and lower extremities
    - Rectal tone (if concern for cauda equina syndrome)
- For Spine consultations – please check on-call schedule on WebXchange to determine whether Neurosurgery or Orthopedic Surgery is covering spine call, unless patient has previously been seen by Neurosurgery for Spine consultation/treatment in the past.
- For any patients with concern for osteomyelitis/discitis or abscess please obtain blood cultures, ERS, CRP, and CBC. If no concern for sepsis or when clinical situation permits, please avoid starting broad spectrum antibiotics.
- For consultations for symptomatic carotid stenosis, ischemic, or hemorrhagic stroke please ensure that the Neurovascular Service is also consulted.
- For trauma patients transferred to the ED from an OSH, please ensure radiology reads and images related to neuro imaging is requested or available from OSH
- Our resident consult coverage changes at 5:30 am and 5:30 pm. Any consults placed after 5:30 pm will be seen overnight and assigned to a Neurosurgery service. For consults placed the day prior or before 5:30 am please contact covering Neurosurgery service noted at bottom of consult note to discuss any follow-up questions or plan of care. Neurosurgery 1: x9576, Neurosurgery 2: x9541, Neurosurgery 3: x7048.

Consult Courtesy Guidance Document

Consult Team: Benign Gynecology

Program/Department: Obstetrics and Gynecology

Stat Pager: 3811

Questions Pager: 3811

Courtesies:

- Please obtain transvaginal ultrasound (with finalized read) in setting of post-menopausal bleeding prior to placing a consult unless the situation is acute
- Heavy vaginal bleeding in premenopausal woman warranting inpatient consult includes patient soaking through 1-2 pads/hour, hemodynamic instability, or severe anemia. Otherwise, this can be addressed as an outpatient and an ambulatory referral can be placed.
- Most contraceptive needs (nexplanon, IUDs, etc.) should be handled as an outpatient except in extenuating circumstances. Please place ambulatory referral upon discharge.
- GYN should not be a consulting service for pelvic exams. We ask that you complete a pelvic exam and attempt to address minor complaints (i.e. - problems that a general practitioner would see in the office like vaginal discharge, etc.) prior to consulting GYN inpatient
- Please consult us for pap smears on all transplant patients.
- For all other routine pap smears, please place an outpatient referral to the clinic. However, if the GYN team is consulted for another reason we are happy to perform it.

Consult Team: Gynecologic Oncology

Program/Department: Obstetrics and Gynecology

Stat Pager: 3811

Questions Pager: 3811

Courtesies:

- All initial Gynecologic Oncology consults or inquiries should go through the 3811 pager. We will triage to the appropriate resident and they will contact you directly.
- We would prefer that a full lab and imaging workup be completed prior to the consult being placed unless the patient is hemodynamically unstable.

Consult Courtesy Guidance Document

Consult Team: Obstetrics

Program/Department: Obstetrics and Gynecology

Stat Pager: 3811

Questions Pager: 3811

Courtesies:

- Please obtain transvaginal ultrasound (with finalized read) and serum quantitative bHCG in the setting of a pregnancy of unknown location and missed or incomplete abortion prior to placing a consult unless the situation is acute.

Consult Team: Ophthalmology

Program/Department: Ophthalmology

Stat Pager: Ophthalmology: Resident First Year (in WebXchange)

Questions Pager: Ophthalmology: Resident First Year (in WebXchange)

Courtesies:

- Prior to placing a consult – ask the patient if they are already established with an eye doctor for their current eye problem and obtain records.
- If consulting for blurry vision please provide a measure or estimation of visual acuity (ie smallest line they can read on your badge) and whether a complaint is regarding one eye or both
- By default, all patients will have dilated fundus examination, please indicate whether dilation is contraindicated or if there will not be sufficient time (45min to 90min) to complete full exam due to planned testing/procedures
- Consults are not needed for questions about glaucoma medications or routine IOP checks. Please page on-call resident with questions.

Consult Team: Orthopaedic Surgery

Program/Department: Orthopaedic Surgery

Stat Pager/Number: per WebXchange

Questions Number: 30151

Courtesies:

- Always obtain an X-Ray of extremity in question before consulting.
- If infection, please obtain CBC, ESR, CRP. When patient clinical status allows, antibiotics should be held until intra-operative or aspiration cultures are obtained.
- If worried about septic arthritis or compartment syndrome, please make patient NPO as these are surgical emergencies
- We do not do bone biopsies. There is order in IHIS- MSK radiology/IR will do these.
- If patient has orthopaedic problem that can be managed as an outpatient (rotator cuff tear, osteoarthritis, etc.), we do not need to be consulted as an inpatient for recommendations on follow-up. Please place ambulatory referral to orthopaedic surgery. We have an algorithm that will ensure the patient to be seen by correct provider.

Consult Team: Inpatient Hospice and Palliative Medicine

Program/Department: Internal Medicine
STAT Pager: per WebXchange/Qgenda
Questions Pager: per WebXchange/Qgenda

Courtesies:
General:

- Please ensure to place your working contact phone number in the consult order.
- Please ensure clear reason for consult is listed in the consult request.
- If any suspicion or documented history of substance use disorder please document in the consult.

For pain/symptoms:

- We are able to see any of the following for pain/symptoms:
    - Any symptom related to cancer or cancer treatments
    - Pain in sickle cell disease
    - Pain/symptoms in the critically ill
    - Pain/symptoms in the dying patient or patients who are DNRCC
    - Patients whose pain is managed by outpatient OSU Palliative
- For pain medication management outside of the above context, consider instead for anesthesia chronic pain consultation. This includes
    - Chronic non-cancer pain management (including patients with cancer whose pain syndrome is unrelated to and/or pre-dates their cancer or treatments)
    - Chronic non-cancer pain in patients recovering from critical illness and transferring out of the ICU
    - Chronic non-cancer pain in general med-surg patients
- For other symptoms outside of this specific context, please refer to the appropriate specific subspecialty (eg GI, psychiatry, etc.)

For GOC consults

- Please provide 24-hour notice prior to family meetings

Consult Courtesy Guidance Document

Consult Team: Physical Medicine and Rehabilitation

Program/Department: Physical Medicine and Rehabilitation

STAT Pager: PMR New Consult 1st Call Res Day (in WebXchange)

Questions Pager: PMR New Consult 1st Call Res Day (in WebXchange)

Courtesies:

- Pain management
    - Please indicate if looking for possible inpatient pain procedures-a separate team within the PM&R consult service will see these consults.

- Baclofen pump
    - If there are questions/concerns regarding a patient's baclofen pump, please page on-call "Baclofen Pump" APP or attending.
- Spasticity
    - For acute worsening of chronic spasticity, please rule out infectious etiologies, perform skin rounding/assessment, ensure patient is having adequate bladder/bowel function, and ask patient for any recent anti-spasmodic medication changes.
- Inpatient Rehabilitation (IPR) needs
    - If both PT and OT are recommending IPR, placing only the "Dodd request" order is encouraged (not IP PM&R consult).

Consult Team: Inpatient Psychiatry

Program/Department: Psychiatry

STAT Pager: 8177

Questions Pager: 8177

Courtesies:

- If the reason for consult is suicidal ideation, please ensure the SAFE-T assessment (Dot phrase: .SAFET) is completed and documented in a note. This will help the primary team determine what risk level the patient is and whether a 1:1 sitter is needed prior to the consult.
- Please put in a specific question in the consult information with what help is needed. A lot of the time, we get consults which say "suicidal ideation" or "patient is requesting to speak with someone" which are generally not as helpful and require more information prior to our assessment.
- Psychiatry consults can be quite time intensive so it is important to order the consult as early as possible in the day to ensure it is seen in a timely manner.

Consult Team: Inpatient Pulmonary Medicine

Program/Department: Pulmonary/Critical Care Medicine

STAT Pager: 1809

Questions Pager: 9440

Courtesies:

- If the reason for consult is hypoxia, please ensure patient has had a recent CXR
- If there are questions about imaging modalities, please contact on-call pager prior to placing consult
- If placing a STAT or Urgent page after 5PM, please contact the MICU fellow on call (#30523) rather than the Pulmonary fellow on call as they may not be in the building anymore. This particularly applies to Urgent/STAT consults placed after 8PM

Consult Team: Podiatry

Program/Department: Podiatry

STAT Pager: Resident-on-call

Questions Pager: Resident-on-call

Courtesies:

- Please obtain an X-Ray before consulting. Upon our assessment, we will inform you if an MRI is indicated.
- If infection, please obtain CBC, ESR, CRP. When patient clinical status allows, antibiotics should be held until intra-operative or aspiration cultures are obtained.
- Nail and callus care can be handled on an outpatient basis; you can make an outpatient referral on discharge
- We recommend ABIs for patient's suspected to go to surgery. Vascular team and podiatry work closely together
- We have a relatively small team. Our on-call resident covers the Main and East hospitals at the same time. This creates times when we are not on site and immediately available. We will respond as quickly as possible; however, for urgent matters, please page us directly.

Consult Team: Inpatient Radiation Oncology

Program/Department: Radiation Oncology

STAT Pager: 0674

Questions Pager: 0674

Courtesies:

- For oncology patients or suspected oncology patients, please obtain pathology reports or have a pathological diagnosis in IHIS available prior to placing the consult. (Exceptions would be for spinal cord compression/cauda equina syndrome or suspected emergencies)
- If a patient is currently receiving radiation treatments, please call the radiation oncology charge nurse at x62121 to inform them the patient is admitted. The nurse will reach out to the physician to determine if treatment is appropriate. There is no need for an inpatient radiation oncology consult unless there is a new issue that is unrelated to their current treatment.
- For any questions, page the resident on call at 0674.

Consult Team: Interventional Radiology

Program/Department: Interventional Radiology/ Radiology

Stat Pager: The on call IR resident/fellow pager in WebXchange

Questions Pager: Same as above after hours

Courtesies:

- For all daytime consults please list a phone or pager number for the individual or team that is consulting IR.
    - For questions pertaining to procedure scheduling, please first reference the patient calendar in Epic. If the procedure is not yet listed, you may contact the IR charge nurse at 66186 (UH) or 89299 (James) with questions.
    - For physician level questions pertaining to your consult, please page the IR resident covering UH (x3598) or James (x3599).
- STAT consults after normal business hours (5p-7a) and on the weekends are covered by a single resident taking home-call, covering UH, the James, and UHE. Please send a separate page to the on-call resident with a cell phone or landline contact number. After hour STAT consults will be addressed immediately but non-emergent/non-urgent consults will be worked up the following morning.

- For high risk procedures, please obtain an updated Coag panel including INR and platelets, as well as a recent H/H. Electrolyte abnormalities (e.g. hyperkalemia) should be corrected prior to IR procedures. Emergent scenarios will be addressed on a case-by-case basis.
    - General requirements for IR procedures: INR<1.5, Plts>50K, Hgb>7.0, and NPO x 6 hrs (for moderate sedation). For cases requiring general anesthesia, please reference the Anesthesia guidelines as patient may need to be NPO for over 8 hrs.
- General Anesthesia is typically needed for patients with severe cardiac or pulmonary issues and any patient that cannot tolerate lying flat, either supine or prone depending on the procedure, while under moderate sedation. If your patient requires general anesthesia our team will coordinate this with the on-call Anesthesia team.
- Regarding withholding anticoagulation prior to procedures, please reference the Society of Interventional Radiology consensus guidelines: Society of Interventional Radiology Consensus Guidelines for the Periprocedural Management of Thrombotic and Bleeding Risk in Patients Undergoing Percutaneous Image-Guided Interventions—Part II: Recommendations - Journal of Vascular and Interventional Radiology (jvir.org)

Consult Team: General Surgery (emergent) or General Surgery (elective)

Program/Department: General Surgery

Stat Pager: 9525

Questions Pager: 9525

Courtesies:

- Please place STAT consult only if truly an emergent question that needs to be seen and staffed with an hour. For example, acute appendicitis, cholecystitis, PEG tube placements, wound debridements are not STAT consults. *This helps us triage consults when we are scrubbed in the OR*
- FYI – we see any consult that comes in during our shift regardless of routine, urgent, or STAT so we will see it and staff within 14 hours no matter what urgency is conveyed to us.

Consult Team: Inpatient Urology

Program/Department: Urology

Stat Pager: Urology consult pager listed on WebXchange

Questions Pager: Urology consult pager listed on WebXchange

Courtesies:

- Post-operative Urinary Retention now has an inpatient algorithm – this does NOT have to be an official inpatient consult, we have a documented form for the new algorithm that most surgical services have now but can be sent out as needed. This information is below.
- A void trial must be attempted inpatient. We recommend starting Flomax prior to void trial. We recommend start Flomax on POD0 if they can take oral.
- If they fail a void trial, return the Foley catheter OR have inpatient nursing teach patient on clean intermittent catheterization (CIC). We do not do this. Nursing have the capacity to do this.
- You can use the same lingo we use to tell the patients- We don't know why some men are unable to urinate after surgery. A lot of the time is induced by anesthesia and over time it usually passes. If you had difficulty urinating prior to surgery, such as weak stream, urinary hesitancy, or difficulty emptying your bladder, this can be exacerbated after having anesthesia. Most men pass the void trial on the second try after the catheter has been in place a little longer, or if you want to learn to do CIC it does slightly lower infection risk. If not, urology will discuss with you on options in clinic.
- If patient desires to do CIC, case managers need to set up intermittent cath supplies upon discharge. It is a “custom order” which needs to include catheter size, frequency, reason for use, duration of use, lubrication. If coude, the diagnosis of BPH or diagnosed anatomic rationale.
- If a patient has an outside urologist, they can follow-up with them for a voiding trial. If the patient does not have an outside urologist, place an ambulatory referral to urology: In comment section, state "void trial." Once referral is placed, please make sure that case managers have up to date contact information for patient. They should get a call within 24-48 hours notified of their appointment. It is also the job of the case managers to make sure that it is scheduled. We will make sure on our end (our Urology schedulers) will have that posted on their schedule in 24-48 hours.
- Please know that void trials are scheduled within 1-2 weeks period. Our clinic load does not have the capacity to have a void trial in 1-2 days after discharge.
- Usually once the appointment is scheduled, a message gets sent to the attending who approved the order. Please let us know if this does actually happen to close the loop. If not, we need to do more internal research on how to best notify.
- Difficult Foley placement: If unable to place standard catheter, 18 French coude catheter should absolutely be tried by Nursing or the primary team first (if not present on floor, they need to contact central supply or OR) before contacting Urology. If unable to be placed, Urology can trial placement - BUT nursing or primary team needs to reach out to Urology consult resident to inform them of the difficulty and where is the difficulty. If Urology can place without significant complications, no consult is necessary.

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Consult Courtesy Guidance Document

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History

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