SMH-Venice Admission Guidelines by Specialty - update approved on 08/26/2025 by SMHCS Board.

I. **Cardiology**
   a. The Hospitalist service will admit cardiac admissions except:
      i. Patients with ST segment elevation MI's taken directly to Cath lab from the Emergency Department should be admitted by Cardiology.
      ii. Patients with non-Q wave MI who in the combined opinion of the Emergency Physician and Cardiologist must go directly from the Emergency Department to the Cardiac Cath Lab should be admitted by Cardiology.
      iii. In the event the patients from a and b from, above are found after catheterization not to have a cardiac diagnosis then the cardiologist may consult the hospitalist service to determine if the patient is appropriate for the transfer of care to a medical service.
      iv. Patients who underwent an outpatient cardiac admission and procedure and subsequently return to the Emergency Department within 24 hours with a complication from that procedure should be admitted by Cardiology including Electrophysiology.
   b. Patients presenting with Cardiac Arrhythmia with hemodynamic instability to the Emergency Department should be stabilized in the Emergency Department with Cardiology providing stat consultation by phone or in person as decided in consultation between a Cardiologist and the Emergency Physician. Once stabilized the patient should be admitted by Hospitalist service with stat or urgent or routine cardiology consultation as required. In the event the patient cannot be stabilized in the Emergency room and is admitted then that patient should be admitted to the Intensive Care Unit with stat or urgent Cardiology support as required
   c. Cardiac Patients transferred from another facility who in the combined opinion of the Emergency Physician and the Cardiologist do not require to proceed directly to the cardiac cath lab should be admitted to the Hospitalist service.
   d. Patients who present with non-Q wave MI and are admitted to the Hospitalist service and who will most likely require a cardiac catheterization in the subsequent 24 hours may benefit from preferential admission to the post PCI floor if available.
   e. All other cardiac patients will be admitted to the Hospitalist Service

II. **Gastroenterology**
   a. Will consult any patient who presents to the emergency department with a complication following a GI procedure in the office or endoscopy center. If the patient has associated medical problems, the hospitalists' team will admit if necessary.
   b. Will provide care for all patients presenting with a food bolus and coordinate care with other services for those patients requiring admission.
   c. Patients with multisystem disease will continue to be admitted by the hospitalists, with a consult to the gastroenterologists.
   d. Unassigned patients presenting to the emergency department with inflammatory bowel disease will be admitted by the hospitalists, with a consult to the gastroenterologists.

III. **General Surgery**

a. Admitted by general surgery:
   i. Acute appendicitis
   ii. Surgical conditions needing OR within 24 hours.
   iii. Surgical complications (deep abscess, perforation etc.) of surgeries done (in- house or by SMH credentialed surgeon) in 30 days.

b. Admitted by primary care or Hospitalist.
   i. Bowel obstructions
      1. if needing OR within 24 hours- admit to surgery
   ii. Medical complications (DVT, superficial wound infection) of surgeries

c. Case by case
   i. Surgical complications of surgeries done (off site by non-SMH credentialed) in 30 days
      1. Medical hospitalist may admit and consult on call surgeon, unless surgeon is willing to admit for any reason.

IV. **Infectious Disease**

a. The hospitalist service(s) admit the majority of all infectious disease admissions.
b. The ID physician should call the hospitalist when they are preparing to send a patient in for admission.
c. Patients coming from ID offices and Wound Care Centers are admitted directly to the inpatient bed. Physician to physician communication necessary. ID Physician to call the transfer center for the hospitalist to admit. Do not send to the emergency department.

V. **Inpatient Rehabilitation Facility (IRF):**

a. Not applicable

VI. **Nephrology:**

a. The hospitalist service(s) admit nephrology patients and then consult the nephrologist.

VII. **Neurosciences**

a. Neurology – Refer to Addendum: Stroke algorithm.
b. Neurosurgery –
   i. Traumatic head and spine injury will initially be evaluated by the Emergency Room and neurosurgical consultation will be requested as needed when appropriate care can be provided.
   ii. Intracranial hemorrhage (non-traumatic): will be evaluated by the Neuroscience Department Staff. This includes hemorrhagic strokes in the form of subarachnoid hemorrhage (SAH) and spontaneous intraparenchymal hemorrhage (IPH) as well as non-traumatic subdural hemorrhage (SDH)
      1. SAH – will be initially evaluated by Neurosurgery.
         a. Clearly non-aneurysmal SAH, as determined by the Neurosurgery on-call physician by review of the patient's imaging and history, will be admitted by the Hospitalist.
         b. Any SAH suspicious to be aneurysmal or of a vascular malformation in nature, as determined by the Neurosurgery physician on-call, will be transferred to the Sarasota campus.

c. In the rare case that a patient is admitted to the Hospitalist or Medicine service and is later found to have a ruptured aneurysm, Neurosurgery will accept the transfer of care and become attending unless the family only desires palliative care.

2. IPH – will be evaluated by the appropriate Neuroscience Staff according to our ICH Triage document and will be admitted to the Hospitalist.
3. SDH – non-traumatic SDH (either acute or chronic) will initially be evaluated by Neurosurgery.
    a. Any patient that requires immediate surgical care will be admitted to Neurosurgery.
    b. Patients that do not require immediate surgical care will be admitted to the Hospitalist.

VIII. **Obstetrics/Gynecology**

a. Patients whose presenting diagnosis is primarily obstetrical or gynecological will be admitted to OBGYN service.
b. Pregnant patients whose primary diagnosis is non-obstetrical will be admitted as per following guidelines:
    i. Pregnancy duration of (less than) < 20 weeks will be admitted to the provider that specializes in the primary diagnosis- medical hospitalist, surgical hospitalist etc. OBGYN will be consulted related to the pregnancy as needed.
    ii. Pregnancy duration of (greater than or equal too) > 20 weeks will be generally admitted to OBGYN. Other providers- medical hospitalists, surgical hospitalists etc. will be consulted as related to the primary diagnosis.
    iii. There might be situations when patients with pregnancy duration of > 20 weeks may need to be admitted to the provider who specializes in the presenting diagnosis- for example orthopedics, medical hospitalist etc. This will be decided on case-by-case basis. OBGYN will be consulted and remain available in all such cases.

IX. **Orthopedics/ Vascular (2 Options)**

a. Compartment syndrome multi-disciplinary: ECC to reach out to 1 or 2 below as directed by the underlying cause.
    i. Admit Orthopedics for trauma, injury or fracture related to Compartment Syndrome. Medicine to admit/consult as backup if needed.
    ii. Admit Vascular Surgery for all other Vascular originating issues causing Compartment Syndrome. Medicine to admit/consult as backup if needed.
b. Necrotizing Fasciitis: If there is an overlapping area of concern, the general surgeon will determine and consult the sub specialists as needed. The specialist responsible for the care of the patient will be determined based on the location of the affected area of the body. The minimal requirement of care will include a physical exam of the patient by the specialist. Follow up with medicine for admit to medical confirmation.
    i. Extremity involvement – Orthopedics
    ii. Trunk involvement – General Surgery
    iii. Head & Neck involvement – ENT
    iv. Perineum – Gen surgery in conjunction with Urology

X. **Pediatrics/Newborn Infants**

a. There is no dedicated inpatient pediatric service.
b. Infants delivered at SMH-Venice will be admitted to a pediatric provider on staff.
    i. Established patients will be admitted to their pediatrician on staff.
    ii. Unassigned patients and patients with a non-staff PCP will be automatically admitted to the neonatology service, with care provided by the neonatal nurse practitioner.
    iii. Infants presenting to the SMH Emergency Department or one of the Urgent Care Centers will be referred to SMH-Main and the Neonatology service.
c. Pediatric Traumas are transferred to Tampa General or All Children's Hospital

SMH Venice Neurosciences Admission Guidelines

	Keep	Discuss	Transfer
ischemic Stroke	All others	Posterior fossa stroke (neurology) Large hemispheric stroke <70 yo (neurology)	Candidates for interventional thrombectomy
Hemorrhagic Stroke	Small <30 cc supratentorial ICH (neurology)	Intraventricular bleed (neurology) Non-traumatic SDH (nsurg)	Suspected aneurysmal SAH Infratentorial ICH Large ICH > 30 cc
Trauma	Isolated compression fracture	SAH/SDH with GCS > 13 (nsurg)	Poly trauma ICH/SDH/SAH on thinners Patients GCS < = 13

* Any patient/family that does not want aggressive care (comfort measures) may be admitted to the hospitalist or hospice service
** Any patient that is too unstable for transfer or that may require emergent operative care prior to transfer should be discussed
*** Patient's with neurology consults for ICH do NOT need an additional neurosurgery consult

Approved by SMH Neurosciences Dept 2/18/2022.