DEM (Department of Emergency Medicine) referrals – March 2012

Historically all patients coming to ED have either been referred to an inpatient team (by a GP, T Hospital or other health professional) or are "unreferred" and are managed by DEM. . In recent years the scope of Emergency Medicine has expanded such that the care of selected patients can be expedited by a referral directly to the DEM team. Conversely, it has also become more common for GPs to send patients to be evaluated by the DEM, when it might have been better for them to have been managed from the outset by an inpatient team. GPs are phoning DEM doctors more often than previously for advice.

The purpose of this document is to help clarify which of your patients might best be assessed and managed by DEM doctors primarily or are ill or injured enough to need the early involvement of the DEM staff along with inpatient teams. GPs are also invited to phone the ED for advice on this or other emergency clinical issues

Patients who could be referred to DEM doctors:

1. Severely injured or unwell patients who will require immediate intervention or resuscitation on arrival. If such patients also have a clear delineation of their problem and the inpatient team likely to ultimately admit them then this team registrar should be contacted as well.
2. Truly undifferentiated patients whose medical problems potentially require multiple different inpatient teams or when it is unclear who the primarily responsible team should be, especially when the problems may cross between medical and surgical specialities
3. Adults and children with toxicological issues including poisonings and overdose (accidental or intentional)
4. Patients with fractures and dislocations that do not from the outset clearly need to be admitted under the orthopaedic service. This includes all paediatric forearm fractures, most of which are reduced under sedation in ED by the DEM team. It also includes all joint dislocations including shoulder, elbow and hip joint prostheses. The Orthopaedic service should be called from the outset for complex fractures in particularly those that may require surgical repair.
5. Other conditions amenable to being dealt with under procedural sedation (Propofol or Ketamine) in ED that includes:
    - Simple abscesses for I&D (NOT complex abscesses like those on the male or female perineum, anterior neck or face, breast)
    - Time-sensitive electro-cardioversion
    - Simple wounds for suturing
6. Rule-out renal colic (patients with possible but unproven ureteric calculi) not already dealt with by the GP diagnostic pathway
7. Headache rule-out sub-arachnoid haemorrhage. Other headaches such as refractory migraines and rule-out meningitis may also be better managed by DEM doctors
8. Head injury in adults and children with concussion who may need observation or consideration of CT

Please note:

1. Patients who are likely to need to be admitted under an inpatient team must follow the usual agreed process of referral to that team. If the final management and admission is likely to be undertaken by an inpatient service then the patient should be referred to them from the outset.
2. We certainly do not want you to stop referring patients to inpatient teams nor to preclude their involvement (for example orthopaedics in fracture management). Having well differentiated or stable and previously diagnosed patients worked up by the DEM team is redundant and delays definitive care. We are hoping to point out the specific cases where an emergency referral to the DEM team would be an advantage.

GP phone-calls to DEM doctors:

Whilst phone-calls are not routinely required when sending patients (with an appropriate referral letter) we would expect a phone-call via Switchboard asking for the duty ED consultant when:

1. the patient is severely ill or injured requiring early planning of resource allocation
2. advice is sought about assessment, management or whether to send a patient mentioned in 1-8 above, for example if there is uncertainty about early treatment or disposition
3. a GP feels that an inpatient team registrar has unreasonably refused an acute referral of a patient that needs to come to ED (if that inpatient Consultant is not available).