County of Los Angeles **Department of Health Services**

VALLEYCARE
OLIVE VIEW-UCLA MEDICAL CENTER/HEALTH CENTERS
POLICY & PROCEDURE

NUMBER: 2162
VERSION: 1

SUBJECT/TITLE: **NEUROLOGY OUTPATIENT REFERRAL AND ADMISSION GUIDELINES**

POLICY:

I. General guidelines for outpatient clinic referral

Appropriate referrals	Not appropriate
• History of stroke, lacking evaluation	• Stroke with treatable risk factors
• Unstable epilepsy or new onset seizure	• Routine, uncomplicated seizure disorder (non-compliance, low levels, seizure-free, substance abuse, etc.)
• Headache with failed primary care management	• Routine migraine, chronic daily headache, analgesic overuse, opioid dependence
• Peripheral neuropathy with failed primary care management	• Chronic neuropathic pain, fibromyalgia, radiculopathies without deficit
• Neurodegenerative disorders (e.g., Parkinson's)	• Chronic low back or neck pain
• Movement disorders	• Bell's palsy
• Vertigo, disequilibrium	• Light-headedness, dizziness, giddiness
• Multiple sclerosis	• Fatigue
• Neuromuscular junction disorders	
• Muscle disorders	
• Spasticity	

This list is by no means all-inclusive and does *not* replace clinical judgment. It is meant to be a guide.

DO NOT page the consult/on-call resident to schedule or overbook a patient into a Neurology outpatient clinic. The residents do not have the authority to schedule patients or overbook them; those decisions are made centrally at the attending level. If you feel that a patient needs referral to Neurology clinic, please submit a Consultation Request form to the Neurology office. Consultation requests are reviewed and triaged weekly. If the patient is encountered during off

hours, a request may be submitted the following morning. If you feel that the patient needs an expedited appointment, please call the Neurology office or the Chief of the Neurology Department to discuss overbooking the patient.

DO NOT send patients directly to the Neurology Clinic on Tuesdays or Fridays. We have a predetermined limit, in accordance with Nursing, for any given clinic day.

II. Specific guidelines for admission or outpatient referral from the Emergency Room

A. Stroke/TIA

1. TIA. In general, all patients who present with a history suggestive of transient ischemic attacks should be admitted for risk factor assessment. Due to the high immediate risk of ischemic stroke following a TIA and the inefficiencies of outpatient diagnostic testing, inpatient monitoring and assessment ensures comprehensive evaluation and the potential for timely intervention if indicated.

2. Hemorrhagic stroke. In the event of a parenchymal, subdural or subarachnoid hemorrhage, a transfer to LAC-USC should be arranged. The only exception is a parenchymal hemorrhage with symptoms already for more than 5 days, in which case admission to Olive View is permissible.

3. Ischemic stroke. All ischemic stroke patients should be evaluated by the Neurology Service. The timing of consultation shall be determined by the duration of symptoms.

0-4.5 hours: Consultation should occur in the Emergency Department to determine eligibility for intravenous tPA.

4.5-6 hours: Consultation should occur in the Emergency Department to determine eligibility for possible transfer to UCLA for intra-arterial tPA.

6-48 hours: Consultation should occur in the Emergency Department to help determine the appropriate level of care for admission.

48-72 hours: Consultation may be sought after admission (unless symptoms have progressed in a stepwise pattern or if the patient has multiple increasing, stereotypic TIA symptoms, in which case consultation should occur in the Emergency Department). Patients

should be admitted to the intermediate care unit or standard care telemetry ward for 24 hours of observation/monitoring.

>3 days: Consultation may be sought after admission. The level of care for admission is left to the discretion of the DEM attending.

B. Seizures

Patients with established epilepsy do not need consultation following a solitary seizure, if an obvious reason (e.g. non-compliance with meds, concomitant illness) for the breakthrough exists. If the patient has had a 20% increase in seizure frequency in the recent past, then a request for an earlier appointment may be submitted if the patient's scheduled visit to Neurology Clinic is >1 month into the future.

Patients who have run out of anticonvulsant medication(s) may be given a supply to cover them until the next scheduled Neurology Clinic visit. If an appointment does not exist, then a 5-month supply should be given and a Request for Outpatient Consultation form submitted.

If a patient has a stable seizure disorder (no seizures on anticonvulsant medication within the past half-year or more) there is no need for the Neurology Service to follow them. Medications may be refilled by Primary Care.

C. Headache

Patients with established migraine headache who have failed documented Primary-Care attempts at management may be referred to the Neurology Clinic. Patients given a new diagnosis of migraine by Primary Care, Medical Walk-In or the DEM, who have not yet had reasonable attempts at management (use of triptans and/or appropriate preventive medications) should be referred to Primary Care prior to seeking specialist care.

D. Dizziness

In all cases of "dizziness," Neurology is best equipped to help patients who exhibit vertigo and/or disequilibrium accompanied by focal neurological signs. Light-headedness, giddiness and chronic dizziness are generally better served by Primary Care, Cardiology, or Head and Neck Surgery.

III. Studies to be obtained prior to Neurology Clinic consultation

The following laboratory tests should be ordered when a consult is made concerning the following common complaints. Having the results available by the time of the Neurology Clinic visit will greatly facilitate and streamline the consult. A complete pertinent history and examination, along with any relevant records of past work-ups, are necessary to evaluate consult requests.

A. Seizures

1. Anticonvulsant levels
2. EEG
3. Brain MRI

B. Headache

1. If DEM referral, the patient should be referred to Primary Care first. If referral from Primary Care, and headache of long duration (>1 year), documentation of a headache history, neurological examination, and prior management attempts.
2. Detailed medication history (abortive, OTC and preventive medications)
3. If the patient is more than 50 years old, ESR
4. Documented neurological examination (to help determine the urgency of the referral).
5. If focal findings on neuro exam, neuroimaging results or at least a request submitted for MRI of brain.

C. Peripheral neuropathy

If painful, medication history - Labs: B12, RPR, TSH, HbA1c, ESR and consider SPEP, ANA EMG/nerve conduction velocities if available

D. Dementia

Do not refer to General Neurology; refer to Dementia Clinic by calling the departmental secretary, x3104. Labs: CBC, B12, TSH, RPR, MHA-TP, Ca, Na, glucose, LFT, BUN, creatinine, homocysteine, folate, lipid panel, brain MRI

E. Stroke

If old, check for MRA of neck or Doppler, echocardiogram, MRI brain - Labs: RPR, ESR, HbA1c, PT/PTT or INR, fasting lipid panel, homocysteine level

F. Muscle Disease
Labs: CPK, ESR, TSH, ANA and EMG

G. Multiple Sclerosis
MRI brain and/or spinal cord with contrast if available - Labs: ANA, B12, ESR, HIV

PURPOSE: Assist other services in appropriate referrals to Neurology Clinic and in-patient admission for neurological problems

DEPARTMENT: All

PROCEDURES:

References:	
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