Common Consult Recommendations

Please update and add to this list!

Consult	Recommendations
Acute ischemic stroke	- Start antiplatelet therapy with __, first dose now. - High-intensity statin - Bedrest for 24-48 hours, with head of bed < 30 degrees - Labetalol 200mg PO q6h prn SBP>220 mmHg, DBP>110 mmHg - Maximize blood glucose control with insulin coverage (keep FS 110-180) - Temperature control (Tylenol prn for temp >100.4F) - Cardiac monitoring - MRI Brain, MRA Head/Neck w/o gadolinium - 2D Echo - Start IVF: Normal Saline @ __ cc/hr - Stroke workup labs: Lipid Profile, HgA1C - Rehab evaluation
Post-TPA	- Start IVF: Normal Saline @ __ cc/hr - Hold antiplatelet and anticoagulation therapy - Neurocritical care consultation - Maintain Blood pressure <180/105mmHg - Vital signs Q15 min x 2 hours, Q30 mins x6 hours, Q1 hour x 16 hours. - Neurochecks Q15 min x 2 hours, Q30 mins x6 hours, Q1 hour x 16 hours. Alert neurology if increase in NIHSS >2 or altered mental status or nausea, headache, vomiting. - Maximize blood glucose control with insulin coverage (keep FS 110-180) ok - Temperature control (Tylenol prn for temp >100.4) - Blood draws can be performed in venipuncture and compressible sites. - Repeat HCT without contrast in 24 hours (or earlier if there is neurologic worsening (NIHSS increase by 2)).
ICH	- Repeat HCT without contrast within __ hours or earlier if there is neurologic worsening (NIHSS increase by 2). - Consult Neurosurgery **- Monitor PTT, INR, Platelets. Correct coagulopathies with reversal agent.** - Seizure ppx? - Start IVF: Normal Saline @ __ cc/hr - Maintain goal SBP 130-150 mmHg, MAP >65mmHg - No antiplatelet or heparin **- Tylenol prn for headache or fever** **- Insulin sliding scale with goal FS 110-180** - NPO

	- Cardiac monitoring - Neuro checks and vital signs Q1 hours with GCS - Bedrest with head of bed > 30 degrees
SAH See z	- Perform CTA of head and neck with contrast to rule out aneurysm or malformation. - Consult Neurosurgery for further management of subarachnoid hemorrhage (i.e neurointervention). - Monitor PTT, INR, Platelets. Correct coagulopathies with reversal agent. - Start IVF: Normal Saline @ __ cc/hr - Start nimodipine 60mg orally or via NGT Q4 hours x 21 days - Maintain goal SBP < 160mmHg - No antiplatelet or heparin - Tylenol prn for headache or fever - Insulin sliding scale with goal FS 110-180 - NPO - Cardiac monitoring - Neuro checks and vital signs Q1 hours with GCS - Bedrest with head of bed > 30 degrees
Delirium precautions	- Delirium precautions/treatment: - limit use of deliriogenic agents if possible (e.g. benzos, anticholinergics, steroids, opiates) - assign bed closest to window - Daytime: lights on, curtains open, minimize napping, frequent one-on-one social interactions & reorientation, & minimize over stimulating environment - Nighttime: lights off, minimize environmental noise, avoid non-essential interventions overnight (e.g. vitals, phlebotomy) - use corrective devices when indicated (e.g. eyeglasses & hearing aids)
Migraine	1. IVF, Toradol, antiemetic (Reglan/Zofran) + Benadryl, 1g IV magnesium infused quickly over 5 minutes 2. Sumatriptan 6mg subcutaneous if no contraindications 3. Can try dexamethasone 10 mg IV - Sumatriptan 100mg as needed (take within 15 mins of headache onset, may repeat after 2 hours if headache returns, not to exceed 200mg/day) Migraine counseling: Patient was instructed to take the abortive medications once the headache starts, and advised to stay in a calm quiet place during headache. Discussed the need to avoid common migraine triggers (artificial sweeteners, food preservative (MSG), aged cheese, skipping meals, change in wake/sleep cycle and intense physical exertion)

	Lifestyle changes that help migraine: physical exercise, fixed meal time, fixed sleep/wake cycle, avoid smoking and highly caffeinated products. Patient was advised to avoid daily use of OTC analgesics which can increase migraine frequency and can cause medication overuse headache. Headache note: -Onset: -Character: -Location: Severity: -Aura: Associated symptoms: no photophobia, phonophobia, lightheadedness, nausea or vomiting. Does not wake the pt up at night. Not associated with bending over, straining. No temporal pattern, No associated lacrimation, injected conjunctiva, rhinorrhea. -Frequency: -Duration: -Increased by: -Decreased by:
Vertigo	1. IVF, antiemetic (reglan/zofran), meclizine 50 mg 2. Epley maneuver when appropriate 3. if still symptomatic valium 5 mg
Reversible dementia workup	- labs: CBC, CMP, B12, methylmalonic acid, folate, TFTs, RPR, HIV - head imaging (CTH/MRI) - depression screen - medication review
Peripheral neuropathy workup	- labs: **CBC, CMP, HgA1c, B12, methylmalonic acid, SPEP with IF,** TFTs, HIV, RPR - Consider ganglioside antibody panel, anti-MAG antibody - EMG/NCS
Non-compressive myelopathy workup	- labs: **B12**, methylmalonic acid, **folate, Vit E, copper**, SSA/SSB zinc, SPEP with IF, HIV, HTLV, ACE, syphilis, Lyme, UTox (heroin)
Seizures	-penems antibiotic as all can lower seizure threshold - seizure precautions - IV ativan prn generalized seizure >1 min - seizure precautions: no driving, operating heavy machinery, bath it ing/swimming alone, cooking alone, working at heights Seizure counseling: Call 9-1-1 if: PM -Any injury was sustained -Shaking or stiffening lasts longer than 5 minutes

	-Patient has back to back seizures -Patient has difficulty breathing -Patient is not returning to normal -Patient is pregnant or diabetic -If patient has been ill or had a fever before the seizure -If patient is combative or agitated after a seizure and is dangerous to themselves or others There is no need to call 9-1-1 if the seizure is short, without injury, typical for the patient, and patient returned to baseline without further event. However, you should still notify your healthcare provider of the breakthrough seizure for further non-urgent management, especially if the number or severity of seizures is more than baseline. We reviewed that for any seizure with impaired awareness, driving is restricted for 12 months per NY'S state laws. We discussed seizure precautions including taking showers, not baths, not working at heights, not swimming alone or being around large bodies of water unaccompanied, not working with heavy machinery, being cautious with open flames and sharp objects. We reviewed the risks of uncontrolled seizures including seizure related injuries, accidents, status epilepticus and sudden unexplained death in epilepsy (SUDEP). Provoking factors for seizures were reviewed and they were counseled to avoid sleep deprivation, more than 2 alcoholic beverages in 24 hours, and to ensure medication compliance. Seizure first aid was reviewed, including if applicable when to administer rescue medication and to call 911 for single convulsive seizure greater than 5 minutes, 2 or more without return to baseline or a seizure with impaired awareness lasting more than 10 minutes.
Orthostatic precautions:	1- Maximize non-pharmacologic measures: I- Maintain adequate hydration II- Instruction to arise slowly in stages (supine to seated to standing). III- Instruct pt to avoid Valsalva-like maneuvers IV- Provide compression stockings and abdominal binders 2- Would consider pharmacological measures like midodrine if above failed
MG	- Evaluate for MG: ice pack testing (apply eye pack to eye with ptosis for 2 min and retest); AchR Ab, anti-MuSK Ab, anti-thyroid Ab; CT chest c/ cont for thymoma - TSH/FT4, Lyme, A1c, HIV, ACE, ANA, RPR - If concerned for MG c/ thymoma, consider anti-striated muscle Ab

	(titin, myosin, actin, alpha actinin), ryanodine receptor Ab - may arrange for repetitive nerve stimulation, single-fiber EMG - please check NIF and VC q4h, bear in mind that -20 and <1L are numbers peri-intubation. - if bedside spirometer numbers are getting worse, consider PLEX - Will consider IVIG. Nevertheless if his clinical condition continues to deteriorate (from MG standpoint) would favor PLEX over IVIG as its effect would be more immediate. - Mestinon needs to be held from oral secretions perspective. - please avoid the following: cardiovascular drugs (blockers and calcium channel blockers, bretylium, procainamide, quinidine), antibiotics (aminoglycosides, macrolides, quinolones, ampicillin),anticonvulsants (gabapentin, phenytoin, trimethadione), antipsychotics (chlorpromazine, lithium, phenothiazines), miscellanea (chloroquine, penicillamine,opioids, statin, thyroxin, and), magnesium sulfate and salts, ophtho drugs (timolol, betaxolol, echothiophate, tropicamide), anesthetic agents (chloroprocaine, ether, halothane, ketamine, lidocaine, NMB).
GBS	[] ICU consultation given rapid progression of symptoms [] NIF/VC [] LP: glucose, protein, cell count, culture/gram stain, BioFire panel, Lyme ab, VDRL, WNV, oligoclonal bands, IgG index, cytology (at least 10cc). [] Serum: aldolase, TSH, ACE, HIV, RPR, ESR, CRP, ANA, dsDNA, smith, SS-A, SS-B, anti-ganglioside abs, anti-AChR, anti-MuSk [] Will decide on further treatment after LP results (PLEX vs IVIG) [] MRI brain with and without contrast? [] MRI C/T/L with and without contrast?
Brief neuro exam	MS: alert and oriented x3, attention, fluency, naming, reading, repetition & comprehension intact CNs: pupils equal and reactive, normal VF, EOM intact, normal face sensation, face symmetrical, normal hearing to speech, tongue midline MOTOR: normal tone/bulk, 5/5 throughout REFLEXES: +2 throughout, ankle mute, toes downgoing SENSORY: intact to PP in all extremities Coord: intact FTN and HTS Gait: able to ambulate, and tandem
Extra spicy neuro exam	MS: alert and oriented, attentive, follow simple commands. CNs: pupils equal and reactive, EOM intact, face symmetrical, normal hearing to speech Motor: normal tone/bulk, move all extremities symmetrically Coord: intact FTN Gait: deferred
Lumbar puncture (LP)	- Consent form

checklist	- Hold anticoagulation prophylaxis ● Lovenox (DVT prophylaxis) hold for 12 hours ● Heparin (DVT prophylaxis) ok to continue ● Apixaban hold for at least 48hrs ● Aspirin 75mg is ok to continue. - Coags: INR/PT/aPTT - CSF Orders (CSF glucose, protein, cell count, culture, gram stain, BioFire panel, HSV, CMV) - Print labels - Lidocaine 2% 2mg subQ - LP Kit - Sterile gloves —--- How to send flow cytometry at KCH: - Call the chemistry lab to send you the required form by chute (D6S station number is 16) - Fill out the form, and send it back with the sample —--- How to send cytology at MMC: - Get MMC cytology request form (which should be obtained from pathology lab at 5th floor Gellman): - Check off the specimen type (CSF, lumbar/spinal I believe) - We need to put pt identifier (name tag) - Fill out the responsible physician name (attending) and collection dateLumbar - Fill out the part for clinical info (like a brief info and why you do LP) MMC: You have to search for them exactly as follows: **Oligoclonal Bands**: Oligoclonal Banding, CSF and Serum **Serum NMO**: Neuromyelitis Optica (NMO) Ab **CSF NMO**: NMO/AQP4 FACS, CSF **CSF Glucose**: Glucose, CSF **CSF Protein**: Search “Protein, Fluid” and then type “CSF” as source **CSF Gram stain/culture**: CSF Culture and Smear **Serum MOG**: MOG Ab Reflex to Titer **CSF MOG**: MOG Ab Reflex to Titer, CSF
Transverse myelitis	Imaging: 1. MRI cervical/thoracic/lumbar spine with and without contrast 2. MRI brain with and without contrast Labs: 1. **Nutritional/Toxic**: Vitamin B1, B6, and B12, methylmalonic acid, homocysteine, folate, vitamin E, zinc, copper, urine toxicology 2. **Serum Serologies**: Aquaporin-4, MOG, ANA, dsDNA, RF,

	ANCA, ACE, SSA/SSB, SPEP with IF, ESR, CRP 3. **Infectious**: HIV, HTLV-1, VZV, RPR, Lyme serology 4. **Lumbar Puncture**: CSF glucose, protein, cell count, oligoclonal bands, IgG index, cytology, flow cytometry, Biofire (CSF PCR), MOG, Lyme antibody, VDRL, WNV, cryptococcus. Save 10cc for further testing
Stroke sign-out template	Vitals: BP , HR Exam: NIHSS Labs: A1c , LDL CTH: CTA: MRIb: MRA H&N: 2D Echo: Stroke meds: BP meds: Glu meds: DVT Prophylaxis: PT/Dispo:
Vasculitis Work-up	- Serum: CBC, CMP, LFT, ESR, CRP, Cryoglobulins, ANA, Complement C, p-ANCA, c-ANCa, Toxicology, ACE Levels, TSH, RF, Anti-SSA / Anti-SSB, SCL-70, Vitamin B12, Folate, Vitamin D, Lyme AB Panel, Lupus Anticoagulant Panel, Antiphospholipid AB, HIV, Hepatitis Panel, U/A, VDRL, Blood Cultures - Consider LP: glucose, protein, cell count, IgG, oligoclonal band
Myositis	CK, ESR, CRP, aldolase, LDH, uric acid ,TSH, ANA, SSA, SSB, hepatitis panel
Patient keeper remote access	Login to PatientKeeper Physician Information System™
Optic neuritis due to NMO/MOG flare up	- Infuse Solumedrol 1 gram now for acute management - Would begin Plasma Exchange as soon as possible--needs a non-tunneled catheter and likely needs 4-5 exchanges over the next week. - CBC, CMP, coags, fibrinogen, and ionized calcium before each exchange and contact NY Blood Center. - MRI of the brain and orbits with and without Gadolinium to demonstrate abnormal enhancement of the optic nerve. - Ophthalmology consult, especially for formal visual fields - No need to repeat MOG antibodies
Isolated 6th nerve palsy	- Ophthalmology consult - Labs: A1c, ESR, CRP, RF, ANA, HIV, TSH, Lyme, RPR, ACE,

	ANA profile, B1, B12, folate - MRI brain with and without contrast - MRI orbit with and without contrast - MRA H&N without contrast - Consider LP with cytology
Stroke discharge (UHB)	Primary Stroke Diagnosis: Stroke Etiology: Disposition: *home vs. AR vs. SAR vs. SNF* Discharge NIHSS/last neurological exam: Discharge mRS: Results of Tests: - CTH/CTA: - MRI/MRA: - TTE/TEE/Carotid Dopplers: - A1c/LDL Inpatient Consults: *relevant work up performed and/or diagnoses* Duration and Indication of Anti-Thrombotic Treatment: Statin on Discharge: Cardiac Monitoring/Loop Recorder: *yes/no Follow up Appts: *include tests that need to be followed up*
Hypercoagulation testing for Ischemic Stroke	Lupus anticoagulant, anticardiolipin, CRP, Homocysteine, Lipoprotein(a), Factor V Leiden, Prothrombin G20210A mutation, Protein C, Protein S, Antithrombin
MOCA Test score	Visual-spatial: /5 Naming: /3 Attention: /6 Language: /3 Abstraction: /2 Delayed recall: /5 Orientation: /6 —--------- Total score: /30
tPA/tNK reversal	
Optic neuritis (new onset)	Ophthalmology consult MRI brain with and without contrast

	MRI orbit with and without contrast MRI cervical and thoracic with and without contrast Serum NMO, serum anti-MOG Ab **B12**, methylmalonic acid, **folate, Vit E, copper**, zinc, ANA profile, Anti-DS, SSA/SSB, SPEP with IF, HIV, HTLV, ACE, RPR, Lyme, ESR, CRP, ANCA LP: glucose, protein, cell count, IgG, oligoclonal band, IgG index, cytology, flow cytometry, Biofire (CSF PCR), MOG, Lyme ab, VDRL, WNV, cryptococcus. Save 10cc for further testing Pulse steroids - PPI + monitor fingerstick while on steroids - Infuse Solumedrol 1 gram of now for acute management Will consider PLEX if no improvement in vision
Pre-DMT for MS	CBC, CMP, Vit D, immunoglobulins panel, HIV, Hep C, Hep B core Ab, Hep B surf Ab, Hep B surf Ag, Hep B DNA (if known chronic infection), JCV Ab w/ index, VZV IgG, Quantiferon, HCG (for females)
Leptomeningeal disease/PMD	- MRI brain with and without contrast - MRI of total spine with and without contrast - CT Chest/Abdomen/Pelvis - Serum: ANA profile, Anti-DS, ANCA, ACE, RF, QuantiFERON, RPR, HIV, HTLV, cryptococcus - LP: opening pressure, glucose, protein, cell count, Biofire, gram stain, flow cytometry, cytology, bacterial culture, fungal culture, mycobacterial cultures, AFB smear, cryptococcal antigen, cryptococcus Ag, lyme, WNV, ACE - Consider repeating LP - Consider biopsy (NSGY consult) if the above neg
Headache in pregnancy	**Impression**: Rule out CVST vs PRES vs aneurysm **Imaging**: MRI brain without contrast MRA head/neck without contrast MRV head without contrast Ophthalmology consult **Treatment**: Tylenol, magnesium, Reglan, IV fluids
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	UHB: \\sunyuhb\share\Hotel-08-A\ResEd
Burn out	1- Sleep 2- Grind 3- Suck it up