

CELLULITIS PAIN RISK STRATIFICATION TOOL

UNACCEPTABLE DIAGNOSIS FOR OBSERVATION: SOCIAL ADMIT, FAILURE TO THRIVE, DIZZINESS, UNABLE TO CARE FOR SELF, NEEDS PLACEMENT, UNABLE TO AMBULATE, CHRONIC ... (ANYTHING)		
IF PATIENT MEETS ANY OF THE BELOW CRITERIA , THEN HE/SHE MUST BE ADMITTED, NOT OBSERVED.		
ADMISSION CRITERIA (criteria that exclude the patient from observation level of care)		
<input type="checkbox"/>	Septic or toxic appearance, T > 102F, wbc > 20,000	
<input type="checkbox"/>	Immunosuppressed	
<input type="checkbox"/>	Involves periorbit or orbit, neck, or >9% TBSA	
<input type="checkbox"/>	Extensive tissue damage, sloughing	
<input type="checkbox"/>	Deeper process: abscess, osteomyelitis, deep wound, suspicion of necrotizing fasciitis	
<input type="checkbox"/>	Patient unable to care for self at home	
<input type="checkbox"/>	Patient already failed outpatient treatment	
<input type="checkbox"/>	Unstable vital signs	
<input type="checkbox"/>	Bite or puncture wound	
<input type="checkbox"/>	Post op infection	
<input type="checkbox"/>	Associated with diabetic ulcer	
PATIENT MUST MEET ALL OF THE BELOW CRITERIA FOR OBSERVATION - CHECK APPLICABLE BOX(ES)		
THIS RISK STRATIFICATION MUST BE COMPLETED AND PLACED IN THE CHART.		
OBSERVATION CRITERIA (inclusion criteria that make observation level of care a possibility)		
<input type="checkbox"/>	H and P consistent with cellulitis	
<input type="checkbox"/>	Require > 1 dose parenteral antibiotics	
Observation Unit Disposition Decision		
WBC nearly normal or significantly improved	All criteria present	HOME
Stable vital signs		
Taking po fluids and meds		
Area of cellulitis not increasing		
No response to iv therapy, rising wbc	Any criteria present	ADMIT consider expert advice
Inability to take po fluids or medicines		
Increase in skin involvement, fluctuance		
Temperatures failed to significantly improve		
Unable to care for self, no home care		

LEVEL OF CARE DETERMINATION AFTER RISK STRATIFICATION (Check One):

- Observation**
- Admit** (Use the appropriate admission order forms)

MD Signature: _____ Beeper #: _____ Date: _____ Time: _____