Potential PES Transfer with Alcohol Withdrawal Concern

**Appropriate History and Physical**

- CEC Patient with concern for psychiatric evaluation need
  - History of significant chronic alcohol use (e.g., daily use ≥2 weeks)

- No history of psychiatric illness OR older patient (age ≥ 65)

- Hx complicated withdrawal or recent use (last 2 weeks)?
  - Obtain detailed alcohol/substance use hx:
    - Typical, recent and last use
    - Hx complicated withdrawal

- Evaluate vital signs and mental status:
  - Abnormal
    - Normal VS AND no signs of delirium
      - Initiate CEC Alcohol Withdrawal algorithm
  - Persistent VS abnormalities; Possible delirium
    - Persistent VS abnormalities; Possible delirium

- Severe withdrawal (CIWA>20) or concerning clinical features
  - Admit to Medicine at appropriate level of care

- No withdrawal or mild with oral medications adequate

- Discuss with PES MD, complete EMTALA, and transfer to PES

**Consider broader medical eval and attempt to obtain collateral:**

- Reassuring evaluation
- No safety concerns with pt behavior pattern
- No Statement of Belief after Psych Social Worker eval

- OK for Telepsych per PSW AND cleared by Telepsych?

- Dispo as clinically indicated

- Consider medicine admission at appropriate level of care (vs transfer to PES after specific discussion with PES MD)

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1. Reported or documented history of seizures, delirium tremens, ICU stays, or other features of complicated withdrawal
2. Vital sign abnormalities: T≥38.0°C (100.4°F); HRs≥110; SBP≥180 or ≤100 (2 consecutive); RR≥22; O2 Sat ≤ 95% RA
   Mental status examination: Pt can state name, year/month, location and is free of waxing/waning attentional deficits.
   Providers may elect to use Quick Confusion Scale to formally evaluate degree of delirium, if warranted. [https://doi.org/10.1053/ajem.2001.25769](https://doi.org/10.1053/ajem.2001.25769)
3. Geriatric patients with behavioral disturbance unable to be managed at nursing facilities/LTACs/rehabs less likely appropriate for PES