SMART Medical Clearance Form

If **ALL five SMART categories are checked "NO"** then the patient is considered medically cleared and no testing is indicated.
If **ANY category is checked "YES"** then appropriate testing and/or documentation of rationale must be documented in the medical records and provided to the receiving facility and time resolved must be documented above. For complex case presentations, discussions between receiving and referring facilities are highly encouraged.

		No	Yes	Time Resolved
S	**Suspect New Onset Psychiatric Condition or Features?**	1		
M	**Medical Conditions that Require Screening?**	2		
	Diabetes (FSBS less than 60 or greater than 250)			
	Possibility of pregnancy (age 12-50)			
	Other complaints that require screening			
A	**Abnormal:**	3		
	Vital Signs?			
	Temp: greater than 38.0°C (100.4°F)			
	HR: less than 50 or greater than 110			
	BP: less than 100 systolic or greater than 180/110 (2 consecutive readings 15 min apart)			
	RR: less than 8 or greater than 22			
	O2 Sat: less than 95% on room air			
	Mental Status?			
	Cannot answer name, month/year and location (minimum A/O x 3)			
	If clinically intoxicated, HII score 4 or more? (next page)			
	Physical Exam (unclothed)?			
R	**Risky Presentation?**	4		
	Age less than 12 or greater than 55			
	Possibility of ingestion (screen all suicidal patients)			
	Eating disorders			
	Potential for alcohol withdrawal (daily use ≥ 2 weeks)			
	Ill-appearing, significant injury, prolonged struggle or "found down"			
T	**Therapeutic Levels Needed?**	5		
	Phenytoin			
	Valproic Acid			
	Lithium			
	Digoxin			
	Warfarin (INR)			
	Carbamazepine (Tegretol)			

Date: **Time:** **Completed by:** /

Signature Print

SMART Medical Clearance Form

List of Abbreviations

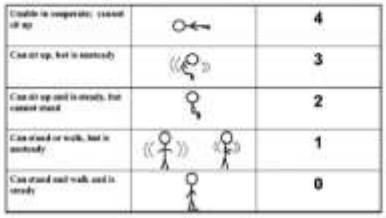
A/O x 3	Alert and Oriented x 3 (person, place, and time)
FSBS.....	Finger Stick Blood Sugar
HII Score.....	Hack's Impairment Index Score
INR.....	International Normalized Ratio
O2 Sat.....	blood oxygen saturation

H-Impairment Index (HII Score)

Time	0)	1)	2)	3)	4)
Gross Motor Function					
Unable to cooperate; cannot sit up	4	4	4	4	4
Can sit up, but unsteady	3	3	3	3	3
Can sit up steadily	2	2	2	2	2
Can stand and walk, but unsteady	1	1	1	1	1
Can stand and walk steadily	0	0	0	0	0
Mentation and Speech					
Unable to cooperate; unintelligible speech/moans	4	4	4	4	4
Slurred speech; does not make sense	3	3	3	3	3
Slurred speech; answers some questions	2	2	2	2	2
Imperfect speech; answers most questions	1	1	1	1	1
Baseline speech; lucid and appropriate	0	0	0	0	0
Tracing Curve					
Unable to participate	4	4	4	4	4
Makes mark on paper	3	3	3	3	3
Traces mostly out side of line	2	2	2	2	2
Traces mostly inside lines	1	1	1	1	1
Traces curve perfectly	0	0	0	0	0
Nystagmus					
Unable to participate	4	4	4	4	4
Profound nystagmus / can't follow finger with eyes	3	3	3	3	3
Moderate nystagmus/ follows finger for short distance only	2	2	2	2	2
Minimal nystagmus/follows finger with eyes whole time	1	1	1	1	1
No nystagmus/ follows finger with eyes whole time	0	0	0	0	0
Finger to Nose Testing					
Unable to participate	4	4	4	4	4
Grossly unsteady/misses targets	3	3	3	3	3
Unsteady and inaccurate/barely touches targets	2	2	2	2	2
Steady/ touches targets, but inaccurate	1	1	1	1	1
Steady/ accurately touches targets	0	0	0	0	0
Total Score					
Health Care Provider Initials					

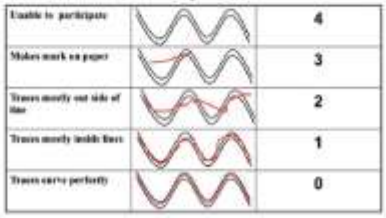
Scoring Reference

Gross Motor Function

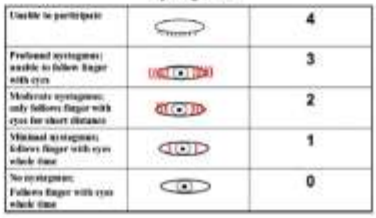


Mentation and Speech

Tracing Curve



Nystagmus



Finger to Nose Testing

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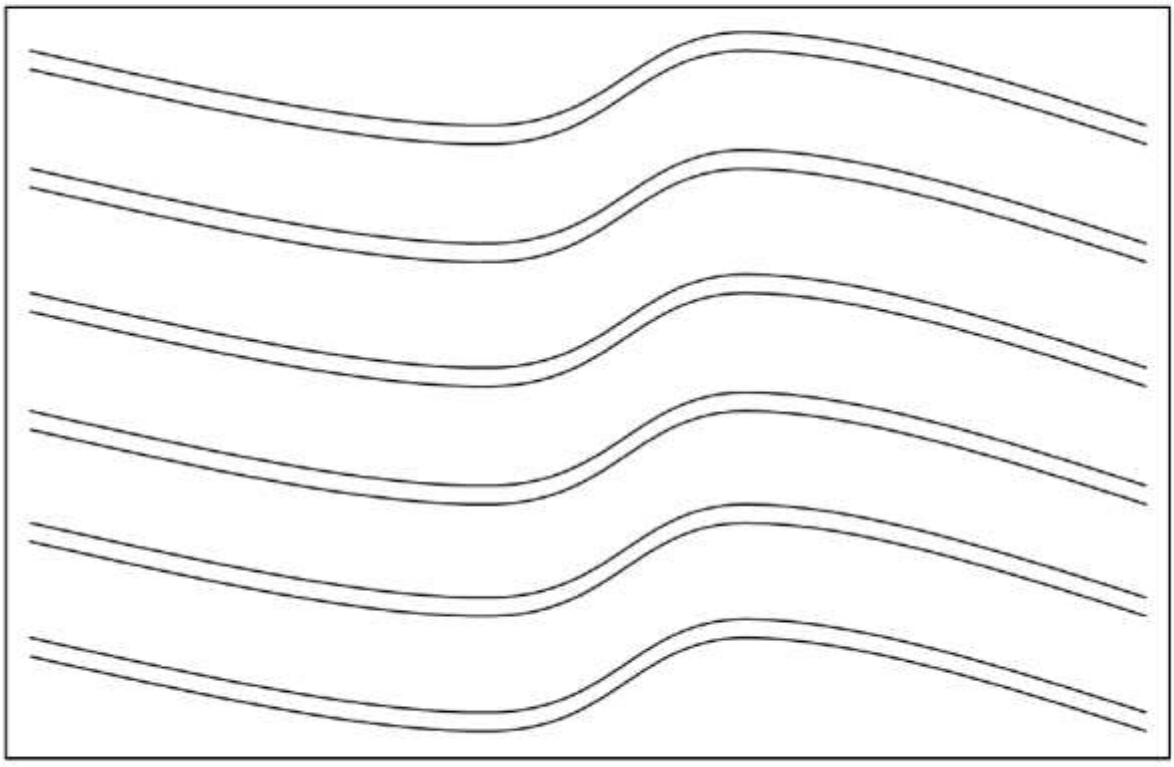
Tracing Curve

Time:



SMART Medical Clearance FAQs

IMPORTANT NOTE ON PATIENT CONSENT FOR VITALS AND LABS

What happens with a patient who refuses blood work, vitals, and/or other assessments like the HII?

The SMART Medical Clearance Form is meant to guide clinicians to an agreed-upon set of standards for medical clearance of patients needing psychiatric hospitalization, however there may be situations where patients refuse vital signs, assessments, or blood draws. A psychiatric patient's legal status does not alter their right to refuse treatment.

In such cases, the clinician should exercise their clinical judgement in using available medical history, previous psychiatric diagnoses, and physician examination in lieu of unobtainable information. Transferring and receiving facilities should collaborate to discuss any refusal and the necessity of routine or alternative tests, while satisfying their respective EMTALA responsibilities to arrange appropriate transfers.

S – Suspect New Onset Psychiatric Condition?

1. **How do you define a "New Onset Psychiatric Condition" or Feature?**
   Using common practice guided by literature, "new onset" typically refers to "new onset psychosis" especially in age extremes given the increased incidence and likelihood of medical etiologies causing their presentations. It is our recommendation that any patient presenting with signs or symptoms consistent with psychosis (hallucinations, delusions, catatonia, thought disorders) without a prior documented history of the same conditions and/or features, warrants a thorough medical assessment including laboratory diagnostics at a minimum to exclude causative organic etiologies. Comprehensive diagnostic testing is not necessarily indicated in patients with new onset depression or anxiety. In such cases, the clinician should rely on their training and exercise their best judgement in selecting appropriate testing.

M – Medical Conditions that Require Screening

2. **What satisfies the question "Possibility of pregnancy (age 12-50)"?**
   For females between the ages of 12 and 50 years, screening for pregnancy is required. However, the reliability of history of pregnancy alone is notoriously inaccurate in most emergency department settings. Therefore, only a urine (UPT) or serum beta-hCG test (qualitative or quantitative) will satisfy this question.

3. **What is meant by "Other complaints that require screening"?**
   This question is meant to remind the provider to assess any other acute or chronic conditions that the patient may present with as they would do with any other individual presenting to the emergency department. Examples may include shortness of breath, chest pain or abdominal pain while chronic conditions may include asthma, chronic kidney disease or seizure disorders. Full diagnostic testing of each of these conditions is not always indicated and should be driven by the clinician's assessment with accompanying documentation of medical decision making.

A — Abnormal

4. **If the patient's vital signs are outside of the reference range, what diagnostic testing, if any, is required?**
   This depends on the specific vital sign in question and the circumstances surrounding the patient's presentation—this could range from thorough documentation of rationale in the provider's medical decision making to a full laboratory diagnostic evaluation.

Adapted from the Sierra Sacramento Valley Medical Society's SMART medical clearance form and process
Updated April 25, 2022

Most physicians are ordering a basic laboratory evaluation (CBC and CMP), +/- UA, urine tox screen, EKG and chest x-ray depending on the specific vital sign abnormality and the patient's signs/symptoms. For instance, in addition to basic labs, a patient with a fever may require a UA, chest x-ray, lactate or blood cultures to identify a source while a patient with isolated asymptomatic hypertension may only require a creatinine to evaluate renal function (end organ dysfunction).

We do, however, strongly recommend that when the vital signs are compared to the SMART reference ranges (see timing in #5 below) that the clinician apply the reference ranges strictly and consistently (i.e., a blood pressure of 181/92 or a heart rate of 111 should be evaluated regardless of presentation).

5. **Regarding timing, which set of vital signs (arrival, evaluation, etc.) do you recommend we use to drive our diagnostic evaluation?**
   The specific vital signs that should be compared to the SMART reference ranges and ultimately drive the diagnostic evaluation are:
   1) vital signs at the time of evaluation by a qualified provider (physician, PA or NP) or
   2) vital signs after evaluation by a qualified provider up to the time of transfer to a psychiatric facility.

   Vital signs at arrival can be problematic and deceiving given that patients typically are anxious, agitated or were recently under the influence of drugs or alcohol. Vital signs that normalize shortly after ED arrival are reassuring and less concerning than those that are persistently abnormal or slowly deteriorate, either of which require thorough documentation of medical decision making, diagnostic testing or both.

   To maintain a conservative lean, we recommend thorough evaluation based upon the vital signs at time of evaluation by a provider or when vital signs begin to fall outside the reference ranges (deteriorate) regardless of recent diagnostic evaluations. Vitals should be repeated as clinically warranted.

6. **For chronic COPD patients (not in exacerbation or treated and back to baseline), is an O2 saturation <95% considered abnormal? If so, what diagnostic evaluation is required?**
   Oxygen saturations of <95% are considered abnormal according to the SMART protocol regardless of whether the patient is in an acute or chronic state. Therefore, at a minimum, we a review of the patient's previous history and thorough documentation.

7. **What is considered an "Abnormal Mental Status"?**
   When performing a focused medical assessment such as we do with the SMART protocol, we are obligated to rule out delirium as a cause of our patient's presentation. At a bare minimum, to pass the mental status portion of the exam, the patient should be "A/O x 3" or be awake, alert and oriented to person, place and approximate time. However, we expect the clinician to have a longer conversation with the patient to allow them the opportunity to gather a history and evaluate their thought process. With a thorough history and adequate conversation with the patient, emergency providers typically perform well when identifying patients presenting with delirium as opposed to a psychiatric cause of their presentation.

   While abnormal, hallucinations alone are not necessarily enough for a patient to be considered as having an abnormal mental status. That being said, patients with new onset auditory hallucinations, visual hallucinations regardless of chronicity, disorientation, inability to concentrate or memory problems all warrant a diagnostic evaluation including basic labs and a urine toxicology screen (see #1).

8. **Is the HII score intended to replace obtaining blood alcohol levels (BALs)? If so, do you repeat the HII score if a patient initially scores 4 or greater or are you required to obtain a BAL?**

When performed in conjunction with screening for the potential for alcohol withdrawal (frequency and quantity of consumption), the HII score is intended to supersede the need for BALs. Given the unpredictable response of individual patients to identical quantities of alcohol consumption, the HII score was developed as an objective assessment of functional capacity in the setting of acute alcohol use and to allow the clinician to determine the degree to which the patient is under the influence.

If a patient initially scores 4 or greater, the patient is determined to be significantly under the influence of alcohol and the test should be repeated until the score is less than 4. The recommended testing interval is 2 hours. If administered regularly by a trained examiner (physician, PA, NP or nurse) there is no indication for obtaining BALs. Furthermore, a HII score of 4 or more should not necessarily delay the mental health assessment by qualified personnel. Referring facilities may utilize breathalyzer to obtain BALs in lieu or in conjunction with the HII as clinically appropriate.

9. **Are labs required for patients outside of the specified age range (<12 or >55)? If so, which ones?**
   Age extremes present a special challenge. While the literature is clear that patients greater than 55 require some degree of diagnostic evaluation, there is a lack of evidence to suggest the right approach in children. Therefore, at a minimum, we strongly recommend obtaining basic labs (CBC and CMP) on patients older than 55 years and recommend basic labs on patients less than 12 years old if they present with a new thought disorder or depression.

   Further diagnostic considerations should depend on the patient's presentation (history and physical) and advanced age should prompt the clinician to strongly consider obtaining more comprehensive diagnostic testing (i.e., UA, imaging).

10. **What should be noted in the physical exam?**
    Physical exam should include notes on physical presentation, physical limitations, durable medical equipment, and any other items or that will accompany the patient to the psychiatric facility.

R — Risky Presentation

11. **What does "Possibility of ingestion" refer to and which patients need screening for ingestions?**
    This is an area that the SMART protocol recommends a low threshold for lab testing to rule out an overdose for patients where overdose is a possible concern. Patients with mild to moderate depressive symptoms are not required to be screened. In otherwise healthy patients who pass the SMART protocol, other screening labs are not necessarily required. Caution should be exercised in patients who are suspected to have taken an ingestion. Comprehensive diagnostic testing should be obtained in those cases.

T – Therapeutic Levels

12. **Are screening drug levels necessary if patients are taking one of the listed medications in SMART but are asymptomatic?**
    Yes, please obtain a screening drug level for patients taking one of the medications listed in in the SMART protocol even if they are asymptomatic. Some emergency departments must send out for results and have significant turnaround times. **Asymptomatic patients should be screened and considered resolved, with results forwarded to psychiatric facilities once results are in.**