Criteria Based Dispatch
Emergency Medical Dispatch Guidelines
Fourth Edition  May, 2004
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Introduction to Criteria Based Dispatch

The Criteria Based Dispatch Guidelines which follow are tools the dispatcher uses to perform the duties of emergency medical dispatch.

Section I  - Medical abbreviations and terminology.
Sections II & III  - Medical Emergencies and Trauma chief complaint categories.
Section IV  - Emergency Medical Telephone Instructions for the most life threatening emergencies.

Each chief complaint category of the Criteria Based Dispatch guidelines includes, Background Information, Dispatch Criteria, Vital Points questions, Pre-Arrival Instructions and Short Report information.

All Callers Interrogation: The All Callers Interrogation is mandatory. The purpose of the All Callers Interrogation is to establish identifying information (name, address, phone number) and to determine the chief complaint. Questions #5 & #6 are designed to determine if the patient is in cardiac arrest and direct the dispatcher to the Emergency Medical Telephone Instructions or to another condition based on chief complaint.

Dispatch Criteria/Response Levels: The Dispatch Criteria describe four separate priority response levels defined according to the urgency in which care must be provided to the patient and the level of care required. Dispatchers should first determine if any MEDIC criteria are present. Only one criteria in the MEDIC category must be present in order for a MEDIC unit to be dispatched. If no MEDIC criteria are present, dispatchers should move to the BLS RED category. If no BLS RED criteria are present, the dispatcher should move to the BLS Yellow category. If no BLS criteria are present the dispatcher should then move to the Telephone Referral Program (TRP) category.

Vital Points Questions: These questions serve two purposes—to assist the dispatcher in identifying the dispatch criteria and to gather additional information to be relayed to responding units. The Vital Points questions are ordered to coincide with the dispatch criteria. However, there is no requirement to ask these questions. If a dispatch criteria is volunteered by the caller, dispatch should be immediate. Mandatory questions are not included on the chief complaint cards.

Pre-arrival Instructions: Pre-arrival instructions should be offered in all cases, except when workload does not allow.

Short Report: The short report consists of the patients age, gender, chief complaint, pertinent related symptoms, relevant medical surgical history, danger to field unit and other agencies responding. The dispatcher provides the short report to the responding units as soon as possible after toning the units out for response.

Emergency Medical Telephone Instructions: Medical instructions for the most life-threatening conditions including cardiac arrest, childbirth, choking and the patient who is unconscious/unresponsive but breathing normally.

Pre-Arrival Instructions, Vital Points questions, Short Report questions and/or Emergency Medical Telephone Instructions should not interfere with answering incoming emergency calls.
Response Modes

MEDIC - Meduc unit (ALS response) and BLS unit, sent Code Red.
BLS - BLS unit (BLS response), either Code Red or Code Yellow, as determined by local agency policy.
Code Red - Units respond with red lights and siren.
Code Yellow - Units obey speed limits and traffic laws.

TRP - Telephone Referral Program - Calls are transferred from dispatch to a consulting nurse line. No BLS unit is sent. If police request a response for a patient that meets TRP criteria, a BLS unit should be sent. (See Police ("P") coding below.)

Initial Dispatch Codes (IDC)

Immediately to the left of each criteria is an Initial Dispatch Code (IDC). This code should be assigned at the time of dispatch and reflects the criteria used by the dispatcher to select the level of response.

• The Initial Dispatch Code may be upgraded or downgraded by the dispatcher during the interrogation, but should NOT be altered by a request from scene for dispatch of a medic unit.
• The final IDC code selected should be based on the dispatcher's decision and must reflect the actual level of response the dispatcher sent on the call.
• The Initial Dispatch Code should never be changed based on a diagnosis or information about the patient received from the aid personnel or paramedics after arrival at the scene.
• When requesting a MEDIC unit to be dispatched into your area, all attempts should be made to relay the IDC to the primary dispatch center dispatching that MEDIC unit.

Special IDC Codes

99M9, 99R9 or 99Y9
There are numerous instances in which an Initial Dispatch Code cannot be assigned to an incident. These include the following types of cases:
1. Still Alarms (walk-ins or calls directly in to a fire station).
2. On view accidents.
3. Interhospital patient transports.
4. When receiving a request for a unit to be dispatched from a communications center that does not use the CBD Guidelines or was not able to interrogate the reporting party, and no IDC Code has been assigned. Always obtain an IDC code if possible.
When sending a medic unit as a primary unit to another jurisdiction, do not use the 99M9 code. Obtain the correct IDC from the center requesting the Medic unit.
The Initial Dispatch Codes for these instances should be as follows:

99M9 - Medic unit was involved.
99R9 - BLS unit only (Code Red) was involved.
99Y9 - BLS unit only (Code Yellow) was involved.

TRP 'P' Codes - If a patient meets the TRP criteria, but police have requested a response, a BLS unit should be sent. These calls should be coded with a 'P' as the letter in the code. For example, a patient meets 21T1 criteria, the call should be coded as 21P1 and a BLS unit dispatched. The 'T' is simply replaced with a 'P' to indicate a police request.
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<tr>
<td>Pt</td>
<td>Patient</td>
</tr>
<tr>
<td>Px</td>
<td>Pain</td>
</tr>
<tr>
<td>RHR</td>
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</tr>
<tr>
<td>R/O</td>
<td>Rule out (determined not to be, as in R/O MI or R/O Fx leg)</td>
</tr>
<tr>
<td>Rx</td>
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</tr>
<tr>
<td>SIDS</td>
<td>Sudden Infant Death Syndrome</td>
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<tr>
<td>SOB</td>
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<td>STHB</td>
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<td>Vital Signs</td>
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Note: When entering information into CAD, use only acronyms consistent with your agency policies.
Glossary of Terms

ABRASION An injury caused by the scraping or rubbing of skin against a rough surface.

ALIMENTARY Organs of digestion.

ANAPHYLACTIC A sudden, severe, often life-threatening allergic reaction that is characterized by low blood pressure, shock, and difficulty breathing.

ANEURYSM Ballooning of an artery due to the pressure of blood flowing through a weakened area resulting from disease, injury, or aneurysm formation.

ANGINA PECTORIS Spasmodic chest pain characterized by a sense of severe constriction in the chest.

ANOXIA Absence or lack of oxygen.

ASCENDING Pertaining to the heart.

ASPIRATE To breathe liquid or foreign material into the lungs.

ASPHYXIA Absence of respiration.

ASEPTIC Sensitive to the heart.

ATELECTASIS Absence of some or all of the lungs.

ATRIAL The main artery from the heart.

AVULSION Forcible separation or tearing away of a body part or tissue.

BRADYCARDIA Slow heart rate, below 60/min.

CEREBRAL Pertaining to the brain.

CARDIAC Pertaining to the heart.

CEREBRAL Pertaining to the brain.

CHEMOSTERILIZATION A method of sterilization involving the use of chemicals.

ATHEROSCLEROSIS A disease characterized by the buildup of fatty deposits in the arteries, leading to narrowing of the blood vessels.

ASTHMATIC Pertaining to asthma.

ASPHYXIA Absence of respiration.

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AVULSION Forcible separation or tearing away of a body part or tissue.
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<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>CERVICAL SPINE</td>
<td>The first seven bones of the spine, found in the neck.</td>
</tr>
<tr>
<td>CHF</td>
<td>Congestive Heart Failure - Cardiac failure, characterized by increased blood pressure and pulmonary edema.</td>
</tr>
<tr>
<td>CLAVICLE</td>
<td>The collarbone or the bone that links the sternum and the scapula.</td>
</tr>
<tr>
<td>CHOLECYSTITIS</td>
<td>Inflammation of the gallbladder.</td>
</tr>
<tr>
<td>COLOSTOMY</td>
<td>An operation in which part of the large intestine is brought through an incision in the abdominal wall to allow the discharge of feces.</td>
</tr>
<tr>
<td>COMA</td>
<td>A state of unconsciousness from which the patient does not respond to external stimuli.</td>
</tr>
<tr>
<td>COMBATIVE</td>
<td>Eager to fight or struggle.</td>
</tr>
<tr>
<td>CONTUSION</td>
<td>An injury in which the skin is not broken; a bruise.</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease - A group of diseases in which there is persistent disruption of airflow into or out of the lungs, including chronic bronchitis and emphysema.</td>
</tr>
<tr>
<td>CORONARY ARTERIES</td>
<td>The blood vessels that supply blood directly to the heart muscle.</td>
</tr>
<tr>
<td>CPR</td>
<td>Cardiopulmonary resuscitation - The artificial maintenance of circulation of the blood and movement of air into and out of the lungs in a pulseless, non-breathing patient.</td>
</tr>
<tr>
<td>CVA</td>
<td>Cerebral vascular accident - A stroke; a condition characterized by impaired blood supply to some part of the brain.</td>
</tr>
<tr>
<td>CYANOSIS</td>
<td>Cyanotic - A bluish or purplish discoloration of the skin due to a lack of oxygen in the blood.</td>
</tr>
<tr>
<td>D5W</td>
<td>An intravenous (IV) solution of glucose (sugar) in water.</td>
</tr>
<tr>
<td>DECAPITATED</td>
<td>Amputation of the head.</td>
</tr>
</tbody>
</table>
DEFIBRILLATION
Electrical shock to the heart muscle to produce a normal spontaneous rhythm. The act to arrest the irregular rhythm of the heart and restore the normal heart rhythm.

DIABETES
A metabolic disorder in which the ability to metabolize carbohydrates (sugars) is impaired, usually because of a lack of insulin.

DIAPHRAGM
A muscular wall separating the thoracic and abdominal cavities. The major muscle of breathing.

DIAPHRAGMATIC
A disorder involving visual and auditory hallucinations from habitual and excessive use of alcohol.

DIASTOLE
The resting period of the heart muscle. Diastolic pressure is the pressure exerted on the internal walls of the arteries during this resting period.

DIAPHRAGMATIC
A disorder involving visual and auditory hallucinations from habitual and excessive use of alcohol.

DIURETIC
A diuretic drug that promotes vomiting.

DIAPHRAGMATIC
A disorder involving visual and auditory hallucinations from habitual and excessive use of alcohol.

DIAPHRAGM
A muscular wall separating the thoracic and abdominal cavities. The major muscle of breathing.

DIAPER
A padded absorbent material worn to absorb and contain urine or feces.

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EPISTAXIS  Nose bleed.
ESOPHAGUS  (Esophageal) - A muscular canal extending from the throat to the stomach.
ESOPHAGITIS  Inflammation of the esophagus.
FEBRILE  Pertaining to fever.
FEBRILE SEIZURE  Febrile convulsions due to high fever in small children.
FEMUR  The thigh bone.
FIBRILLATION  Quivering or spontaneous contraction of individual muscle fibers (applicable in EKG readings).
FIBULA  The outer and smaller of the two bones extending from the knee to the ankle.
FIRST PARTY REPORT  A report taken by talking directly to the patient.
FLAIL CHEST  A condition of the chest caused by severe injury resulting in several ribs fractured in more than one place leaving a segment of the chest wall to move at opposition to the normal breathing motion.
FRACTURE  A broken bone.
GI  (Gastrointestinal) - Pertaining to the stomach and intestine.
GRAND MAL  A seizure or convulsion typically characterized by unconsciousness and generalized severe twitching of all of the body's muscles.
HEMATOMA  A swelling or mass of blood confined to an organ, tissue or space, resulting from a break in a blood vessel.
HEMORRHAGE  Abnormal internal or external discharge of blood.
HIVES  Intensely itching welts usually caused by an allergic reaction to a substance or food.
HUMERUS  Upper bone of the arm from the elbow to the shoulder.
HYPERGLYCEMIA  Abnormally high glucose level in the blood.
HYPERTENSION  A condition of higher blood pressure than that which is considered normal for that particular patient.
HYPERTHERMIA Having a body temperature above normal, >98.6
HYPOGLYCEMIC Deficiency of sugar in the blood.
HYPOTENSION Low blood pressure.
HYPOTHERMIA Having a body temperature below normal, <98.6
HYPOXIA Inadequate supply of oxygen to the body tissues.
HYPOXIC SEIZURE Seizure resulting from an oxygen deficit.
INSULIN A hormone secreted by the pancreas which aids the body in the metabolism of sugar.
IPECAC (Syrup of Ipecac) A dried root of a shrub found in South America, used to induce vomiting.
ISCHEMIA Local and temporary anemia due to obstruction of the circulation to a part.
JEJUNUM That portion of the small intestine that extends from the duodenum to the ileum.
KETOACIDOSIS An accumulation of certain acids in the blood occurring when insulin is not available in the body.
LACERATION A wound or irregular tear of the flesh.
LARYNX Total removal of the larynx.
LARYNGECTOMY A wound or irregular tear of the larynx.
MEDICAL ALERT TAG A bracelet or necklace containing information on a patient’s medical history, allergies, etc.
MADIBILE Mandible
MAXILLA Maxilla
JEJUNUM
LARYNX
LARYNGECTOMY
HYPOXIC SEIZURE
HYPOXIA
HYPOGLYCEMIC
HYPOTHERMIA
HYPOGLYCEMIC
HYPOXIA
HYPOGLYCEMIC
HYPOGLYCEMIC
HYPOGLYCEMIC
MENINGS  The 3 membranes that cover and protect the brain and spinal cord (dura mater, arachnoid mater and pia mater).
MENINGITIS  Inflammation of the meninges.
MI  (Myocardial infarction) - The death of an area of the heart muscle from a deprivation in the blood supply to that location.
MOBILE INTENSIVE CARE UNIT  (Medic Unit) A self contained ambulance staffed by paramedics designed to provide specialized emergency medical (MICU)care for serious conditions.
NITROGLYCERIN  Medication used in the treatment of angina pectoris (chest pain).
OCCLUSION  The closure of a passage.
PALPATION  Examination by touch; generally used to describe obtaining a pulse.
PALPITATION  Rapid, violent or throbbing pulsation, as an abnormally rapid throbbing or fluttering of the heart.
PANCREAS  A large elongated gland situated behind the stomach; the source of many digestive enzymes and the hormone insulin.
PANCREATITIS  Inflammation of the pancreas.
PARALYSIS  Temporary suspension or permanent loss of function, especially loss of sensation or voluntary motion.
PERISTALSIS  The progressive contraction of muscles that propels food down the gastrointestinal tract.
PERICARDIAL SAC  The fibrous membrane covering the heart.
PERITONITIS  Inflammation of the lining of the abdomen.
PETIT MAL  Mild form of epileptic attack, may involve loss of consciousness, but does not involve convulsions.
PHALANGES  The bones of the fingers and toes.
PNEUMOTHORAX  A collection of air in the chest cavity caused by punctures of the chest wall or lungs.
Glossary of Terms (Continued)

POLST - Physicians orders for life sustaining treatment. Formally known as DNR.

RADIUS - The bone on the outer (or thumb side) of the forearm.

RINGERS - Normal saline solution that includes other elements present in blood, such as potassium and calcium.

SCAPULA - Shoulder blade.

SECOND PARTY - A report taken from a person who is with the patient.

SEIZURE - A sudden episode of uncontrolled electrical activity in the brain (convulsion).

SIDS (Sudden Infant Death Syndrome) - The sudden, unexpected death of an infant, which often cannot be explained even after an autopsy. It usually occurs between 1 month - 1 year.

SPOTTING - Vaginal bleeding less than a normal period.

STOOL - Feces.

STOMA - A permanent surgical opening in the neck of a neck breather.

SYSTOLE - The period of muscular contraction of the heart muscle. Systolic pressure is the pressure exerted on the internal walls of the arteries during this period of muscular contraction.

TACHYCARDIA - A heart rate of over 100 beats per minute in an adult.

TELEMETRY - Transmission of medical information (e.g., EKG) via electronic equipment.

TENSION PNEUMOTHORAX - Develops when air is continually pumped into the chest cavity outside the lung and is unable to escape; it is associated with compression of the lung and heart.

SYNCOPE - Fainting (also syncopal episode).

FEvers - A permanent surgical opening in the neck of a neck breather.

REPORT SIDS - A sudden episode of uncontrolled electrical activity in the brain (convulsion).

REPORT SECONDO PARTY - A report taken from a person who is with the patient.

REPORT SEIZURE - A sudden episode of uncontrolled electrical activity in the brain (convulsion).

REPORT SPOTTING - Vaginal bleeding less than a normal period.

REPORT TENSION PNEUMOTHORAX - Develops when air is continually pumped into the chest cavity outside the lung and is unable to escape; it is associated with compression of the lung and heart.
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<td>THIRD PARTY REPORT</td>
<td>A report taken from a person who is neither with the patient nor at the scene of the incident.</td>
</tr>
<tr>
<td>THORAX</td>
<td>The chest.</td>
</tr>
<tr>
<td>TIA</td>
<td>(Transient ischemic attack) - Temporary interference with the blood supply to the brain, like a stroke but without permanent damage.</td>
</tr>
<tr>
<td>TIBIA</td>
<td>The inner and larger of the two bones which extend from the knee to the ankle.</td>
</tr>
<tr>
<td>TRACHEA</td>
<td>The windpipe</td>
</tr>
<tr>
<td>TRACHEOSTOMY</td>
<td>An opening in the trachea made by an operation for use as an airway.</td>
</tr>
<tr>
<td>TRAUMA</td>
<td>An injury inflicted, usually more or less suddenly, by some physical agent.</td>
</tr>
<tr>
<td>TRIAGE</td>
<td>The sorting or selection of patients to determine priority of care to be rendered to each.</td>
</tr>
<tr>
<td>ULCER</td>
<td>A lesion on the surface of the skin or membrane, usually accompanied by inflammation.</td>
</tr>
<tr>
<td>ULNA</td>
<td>The inner and larger bone of the forearm, on the opposite side from the thumb.</td>
</tr>
<tr>
<td>UNILATERAL</td>
<td>One sided (as in stroke).</td>
</tr>
<tr>
<td>VERTEBRA</td>
<td>Any of the bones of the spinal column.</td>
</tr>
<tr>
<td>VERTIGO</td>
<td>An illusion that one's surroundings are spinning.</td>
</tr>
<tr>
<td>XIPHOID PROCESS</td>
<td>The cartilage at the lower end of the sternum.</td>
</tr>
</tbody>
</table>
All Callers - Interrogation

1. What are you reporting?
2. What is the address of the patient?
3. What is the telephone number you are calling from?
4. What is your name? (Optional)
5. Is the person conscious (awake, able to talk)?

   If no: Go directly to Question #6.
   If yes: Go directly to Other Conditions.

6. Is the person breathing Normally? If uncertain: Bring the telephone to the patient and check to see if the chest is rising and falling.

   If no: Go directly to Unconscious and NOT breathing normally below.
   If yes: Go directly to Unconscious and breathing normally below.
   If R/P is still uncertain or describes the breathing as anything other than normal, go directly to Unconscious and NOT breathing normally below.

7. I have advised the dispatcher to send help.* - Stay on the line. (Do not put the caller on hold, unless necessary.)

Unconscious and NOT breathing normally: Dispatch MEDIC response.

   Is there a defibrillator nearby? If premise information is available, tell the caller where the machine is located.
   If yes: Go directly to AED Instructions.
   If no: Would you like to do CPR until help arrives? I can help you with instructions.
   If no: Reassure the caller that the dispatcher has been advised* and stay on the line, if possible.
   If yes: Go to Cardiac/Respiratory Arrest, Section IV. Determine appropriate age group.

Unconscious and breathing normally: Dispatch MEDIC response.

   Go directly to Unconscious/Unresponsive/Syncope, Section II for Pre-arrival Instructions

Other Conditions:
Determine appropriate response level and dispatch Medic or BLS
I have advised the dispatcher to send help* - Stay on the line. (Do not put the caller on hold, unless necessary.)
* Local agency protocols for acceptable wording should be followed.
Abdominal pain may be caused by many conditions, some of which are critical. Background Information

Critical causes of abdominal pain:

- **Myocardial Infarction** ("Angina") which may present as upper abdominal pain or indigestion.
- **Abdominal Aortic Aneurysm** which may present as abdominal pain or back pain ("Flank pain") with or without syncope or near syncope.
- **Ectopic Pregnancy** which may present as lower abdominal pain in women of childbearing age (12-50 yrs) with or without syncope or near syncope. Ectopic pregnancy can occur after tubal ligation and must be considered in all women of childbearing age. A number of problems may make recognition difficult:
  - Problem A: Women who have had their tubes tied, often think they can't be pregnant.
  - Problem B: Young women may deny pregnancy.
  - Problem C: The bleeding may be mistaken for menstruation.

- **GI Bleeding** with vomiting of red blood or dark tarry stools may be critical because of blood loss. Vomiting coffee ground-like material may also be indicative of ulcer disease but suggests much less rapid blood loss and is not usually a cause of syncope. 

Non-critical causes of abdominal pain include:

- gastroenteritis;
- appendicitis;
- bowel obstruction;
- peptic ulcer disease;
- diverticular disease (PDA);
- gynecological conditions;
- gas secondary to constipation;
- kidney stone;
- kidney disease;
- kidney disease per se.

Back pain may also be caused by many conditions. However, b}o}o}m
### Vital Points

- **Ask to speak directly to the patient, if possible!**

  **Medic:**
  - How does the patient look?
  - How does the patient feel when he/she sits up?
  - Has the patient vomited?
    - If yes, what does the vomit look like?
  - Are the patient's bowel movements different than normal?
    - If yes, how would you describe them?
  - Is the pain above or below the belly button?
  - If patient is a woman:
    - Is there a possibility of pregnancy?
    - Has she felt dizzy?
    - Has there been vaginal bleeding, any more than normal?
    - How many pads has she soaked in the last hour?

  **BLS Red:**
  - Is the patient able to speak in full sentences?
  - Is the patient short of breath?

### Abdominal/Back/Groin Pain

- **1M1** Unconscious or not breathing
- **1M2** Signs of shock (three required):
  - Diaphoresis
  - Syncope/near syncope when sitting/standing
  - Pale, clammy skin • Nausea
- **1M3** Vomiting red blood, with three signs of shock
- **1M4** Black tarry stool with three signs of shock
- **1M5** Upper abdominal pain, age > 50
- **1M6** Heavy vaginal bleeding (soaked 3 pads/hr.) with three signs of shock
- **1M7** Lower abdominal pain/stomach/back pain, age > 65, with two or more signs of shock

### BLS Red Response

- **1R1** Pain with vomiting
- **1R2** Signs of shock (one required):
  - Diaphoresis
  - Syncope/near syncope when sitting/standing
  - Pale, clammy skin • Nausea
- **1R3** Flank pain/back pain (kidney stone)
- **1R4** Lower abdominal/stomach/back pain (non-traumatic) age >= 50
- **1R5** No ventilable info available from RP
- **1R6** Breathing Difficulty

### BLS Yellow Response

- **1Y1** Groin injury
- **1Y2** Catheter problem

### TRP

- **1T1** Pain unspecified
- **1T2** Abdominal/stomach/back pain (non-traumatic), age < 50
- **1T3** Chronic back pain
- **1T4** Side pain
- **1T5** Groin pain
- **1T6** Neck/back/shoulder pain (traumatic)

### Pre-arrival Instructions

- **1Y1** Unconscious or not breathing
- **1Y2** Signs of shock (three required):
  - Diaphoresis
  - Syncope/near syncope when sitting/standing
  - Pale, clammy skin • Nausea
- **1Y3** Black tarry stool with three signs of shock
- **1Y4** Upper abdominal pain, age > 50
- **1Y5** Heavy vaginal bleeding (soaked 3 pads/hr.) with three signs of shock
- **1Y6** Lower abdominal pain/stomach/back pain, age > 65, with two or more signs of shock

### Short Report

- **1M1** Unconscious or not breathing
- **1M2** Signs of shock (three required):
  - Diaphoresis
  - Syncope/near syncope when sitting/standing
  - Pale, clammy skin • Nausea
- **1M3** Vomiting red blood, with three signs of shock
- **1M4** Black tarry stool with three signs of shock
- **1M5** Upper abdominal pain, age > 50
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- **1R1** Pain with vomiting
- **1R2** Signs of shock (one required):
  - Diaphoresis
  - Syncope/near syncope when sitting/standing
  - Pale, clammy skin • Nausea
- **1R3** Flank pain/back pain (kidney stone)
- **1R4** Lower abdominal/stomach/back pain (non-traumatic) age >= 50
- **1R5** No ventilable info available from RP
- **1R6** Breathing Difficulty

- **1Y1** Groin injury
- **1Y2** Catheter problem

- **TRP**
  - **1T1** Pain unspecified
  - **1T2** Abdominal/stomach/back pain (non-traumatic), age < 50
  - **1T3** Chronic back pain
  - **1T4** Side pain
  - **1T5** Groin pain
  - **1T6** Neck/back/shoulder pain (traumatic)

### Short Report

- Does the patient have any other medical or surgical history?
- Is the patient wearing a Medic Alert tag?
Background Information

Allergic reactions may be caused by almost anything, with introduction into the body by four mechanisms:

• Ingestion
• Injection
• Inhalation
• Absorption

Critical allergic reactions usually but not always occur with a previous history of reaction. Critical reactions need paramedic evaluation and treatment to maintain an airway in the presence of swelling of the throat and larynx and to maintain blood pressure.

Anaphylactic: A sudden, severe, often life-threatening allergic reaction characterized by low blood pressure, shock (inadequate tissue perfusion) and difficulty breathing.

Critical symptoms of anaphylactic shock:

• Respiratory distress (because of swelling of the throat or larynx)
• Difficulty swallowing (because of swelling of the throat)
• Signs of shock (diaphoresis, syncope, syncope-like response, hypotension)
• Hives
• Swelling at site of bite
• Long duration of time since exposure (greater than two hours)

Non-critical symptoms of allergic reactions include:

• Hives
• Itching
• Swelling at site of bite
• Respiratory distress
• Difficulty swallowing
• Signs of shock

Anaphylaxis/Allergic Reaction

History of severe reaction involving respiratory distress, edema, rash, shock, syncope when similar exposure reoccurs.

Signs of shock (diaphoresis, syncope-like response)

Difficulty swallowing occurs because of swelling

Respiratory distress occurs because of swelling

Anaphylaxis is a sudden, severe, often life-threatening allergic reaction that is characterized by low blood pressure, shock (inadequate tissue perfusion), respiratory distress, and difficulty swallowing.

Critical allergy reactions usually do not occur with a previous history of reaction. Critical reactions need prompt medical evaluation and treatment to maintain an airway in the presence of swelling of the throat and larynx and to maintain adequate tissue perfusion.

Anaphylaxis is a sudden, severe, often life-threatening allergic reaction that is characterized by low blood pressure, shock (inadequate tissue perfusion), respiratory distress, and difficulty swallowing.

Critical symptoms of anaphylactic shock:

• Respiratory distress (because of swelling of the throat or larynx)
• Difficulty swallowing (because of swelling of the throat)
• Signs of shock (diaphoresis, syncope, syncope-like response)
• Hives
• Swelling at site of bite
• Long duration of time since exposure (greater than two hours)
### Vital Points

- **Ask to speak directly to the patient, if possible!**
  - **Medic:**
    - Is the patient able to speak in full sentences?
    - Is the patient short of breath?
    - Is the patient having difficulty swallowing?
    - How does the patient look?
    - How does the patient feel when he/she sits up?

### Anaphylaxis/Allergic Reaction

#### BLS Red Response

<table>
<thead>
<tr>
<th>2R1</th>
<th>History of anaphylactic reaction occurring within 30 minutes of exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2R2</td>
<td>Reaction to medication</td>
</tr>
<tr>
<td>2R3</td>
<td>No verifiable info available from RP</td>
</tr>
<tr>
<td>2R6</td>
<td>Breathing difficulty</td>
</tr>
</tbody>
</table>

#### BLS Yellow Response

<table>
<thead>
<tr>
<th>TRP</th>
</tr>
</thead>
</table>

#### Pre-arrival Instructions

- Have patient rest.
- Keep calm.
- Brush the stinger off, if possible.
- Ice to sting.
- Gather patient meds.
- Do you have an Epi kit? If yes, have you used it? Use as your physician has directed.

### Short Report

- Is the patient wearing a Medic Alert tag?

---

### Dispatch Criteria

#### Medic Response

- **Anaphylaxis**
  - 2M1: Unconscious or not breathing
  - 2M2: Respiratory Distress (one required):
    - Sitting/leaning forward or standing to breathe
    - Speaks in short sentences
    - Noisy breathing
    - Pale and diaphoretic
    - Rapid, labored breathing
  - 2M3
  - 2M4: Swelling in throat, tongue or difficulty swallowing
  - 2M5: Signs of shock (three required):
    - Diaphoresis
    - Nausea
    - Pale, clammy skin
    - Syncope or near syncope when sitting/standing
  - 2M6: Epi pen used by patient/RP

---

2 Allergic Reaction
Critical animal bites in King County are rare since there are no poisonous snakes indigenous to our county.

Critical animal bites requiring paramedic evaluation:

Poisonous snakes require urgent evaluation to expedite access to antivenom treatment.

Uncontrolled bleeding is bleeding that cannot be controlled by direct pressure with a clean cloth or sanitary towel by direct pressure with a clean cloth or sanitary towel. Paramedics should not be dispatched until the RP has attempted to control bleeding without success.

Bites around the face or neck are considered critical because of the possibility of airway obstruction. Therefore, very superficial bites of the face or neck are not critical and do not require paramedic dispatch.

Respiratory distress suggests that either the airway is compromised or the case of a poisonous animal. The airway is compromised if in the case of a poisonous animal, that the ability to breathe is compromised.

Poison control - (206) 526-2121

Responding unit should call Poison Control directly when possible.
**Dispatch Criteria**

**Medic Response**

- **3M1** Unconscious or not breathing
- **3M2** Uncontrolled bleeding
- **3M3** Respiratory Distress (one required):
  - Sitting/leaning forward or standing to breathe
  - Speaks in short sentences
  - Noisy breathing
  - Pale and diaphoretic
  - Rapid, labored breathing
- **3M4** Serious neck and face bites (one required):
  - Airway compromised
  - Decreased LOC
  - Uncontrolled bleeding
- **3M5** Bite from poisonous animal
- **3M6** Signs of shock (three required):
  - Diaphoresis
  - Syncope/near syncope when sitting/standing
  - Pale, clammy skin
  - Nausea

**BLS Red Response**

- **3R1** Bites to face and neck with controlled bleeding
- **3R2** No verifiable info available from RP
- **3R3** Breathing difficulty

**BLS Yellow Response**

**TRP**

- **3T1** Swelling at bite site
- **3T2** Bites below neck, non-poisonous, controlled bleeding

**Vital Points**

- **Ask to speak directly to the patient, if possible!**
- **Medic:**
  - Is the patient able to speak in full sentences?
  - Is the patient short of breath?
  - What part of the body was bitten?
  - Is the patient bleeding?
  - Does the bleeding stop when you apply pressure?
  - What type of animal bit the patient?
  - How does the patient look?
  - How does the patient feel when he/she sits up?

**Pre-arrival Instructions**

- Contain the animal, if possible.
- Keep patient calm and still.
- If bleeding, use clean cloth and apply pressure directly over it.
- **DO NOT REMOVE** apply additional cloths, if needed.

**Animal Bites**

**Short Report**

- Is the animal contained?
- Has animal control been notified?
- Description of animal?

**TRP:**

- Is there any swelling around the bite?
Background Information

Non-traumatic bleeding may be associated with many medical problems.

Patients may be critical due to:

- The amount of blood lost, or
- The underlying problem causing the blood loss.

Uncontrolled bleeding is bleeding that cannot be controlled by direct pressure with a clean cloth or sanitary napkin. Paramedics should not be dispatched until the RP has attempted to control bleeding without success.

Critical symptoms associated with bleeding:

Syncope or near syncope associated with bleeding is usually secondary to a large loss of blood and requires paramedic evaluation and treatment to replenish the lost blood.

Diaphoresis (cold, clammy skin) is associated with shock due to loss of blood from the cardiovascular system.

Vomiting red or dark red blood usually signifies a rapid loss of blood secondary to either GI bleeding or a problem with the esophagus. Vomiting coffee ground-like material usually indicates a much slower blood loss and less critical.

Noncritical instances of bleeding may be:

- epistaxis (bloody nose)
- spontaneous rupture of a varicose vein
- other localized bleeding that is controllable

Bleeding (Non-traumatic)

Black tarry stool usually is associated with a GI bleed with significant blood loss.

Vaginal bleeding in the pregnant woman who is greater than twenty (20) weeks pregnant can be very serious and requires paramedic evaluation.

Hemoptysis (coughing up blood) may cause airway problems and is significant if the amount is greater than a few streaks. Many smokers with bronchitis may cough up smaller amounts of blood without any serious results.

Drugs such as Coumadin or non steroidal anti-inflammatory drugs (aspirin, ibuprofen) may cause stomach bleeding because they weaken the vascular system. Patients taking these drugs may also bleed more freely and profusely because of the drug’s blood thinning and decreased clotting effects.
Dispatch Criteria

Medic Response

4M1 Unconscious or not breathing
4M2 Signs of shock (three required):
   • Diaphoresis
   • Syncpe/near syncope when sitting/standing
   • Pale, clammy skin • Nausea
4M3
4M4
4M5 Vomiting red blood, with three signs of shock
4M6 Black tarry stool, with three signs of shock
4M7
4M8 Coughing up blood, with:
   • Respiratory Distress or • Three signs of shock
4M9 Heavy vaginal bleeding, (soaked 3 pads/hr), with three signs of shock

BLS Red Response

4R1 Bleeding without Medic criteria
4R2 Multiple syncopal episodes (same day)
4R3 Weakness
4R4
4R5
4R6 Uncontrolled nosebleed
4R7 No verifiable info available from RP

BLS Yellow Response

TRP

Vital Points

• Ask to speak directly to the patient, if possible!
  Medic:
  • Is the patient coughing up blood?
    If yes, How much? What does the blood look like?
  • Can the patient speak in full sentences?
  • Is the patient short of breath?
  • How does the patient look?
  • How does the patient feel when he/she sits up?
  • Is the patient vomiting? If yes, what does the vomit look like?
    • How much and how long has he/she been vomiting?
    • Are the patient’s bowel movements different than normal?
      If yes, how would you describe them?
      • Has there been vaginal bleeding, any more than normal?
      • How many pads has she soaked in the last hour?
      • If patient is a woman between 12-50 years, ask: Is there a possibility of pregnancy?

BLS Red:
  • What part of the body is the bleeding from?
  • Is the patient feeling weak?

*Respiratory Infection Screening for Responder protection and advisement - SEE PRE-ARRIVAL INSTRUCTION*

Short Report:
  • Has the patient been taking any medication?
  • If yes, what kind?
  • Does the patient have any other medical or surgical history?

Bleeding (Non-traumatic)

Pre-arrival Instructions

• Have patient lie down, except if nosebleed.
• Nothing by mouth.
• If external bleeding, use clean cloth and apply pressure directly over it. DO NOT REMOVE, apply additional cloths on top if needed.
• If nosebleed, pinch end of nose and do not release.
• If vaginal/rectal bleeding, do not flush the toilet.
• Gather patient meds.

*Respiratory Infection Screening:
  *Does the patient have a fever? If unknown, are they hot to the touch?*
  *Does the patient have a cough? If yes, how long has the cough lasted?*
  *Does the patient have a rash? Note: If fever is present with cough or rash, respiratory protection advised*

Short Report:

• Age
• Gender
• Chief complaint
• Dispatch criteria used to determine response

*Advise Respiratory Protection*
  • Pertinent related symptoms
  • Medical/surgical history, if relevant
  • Other agencies responding

4 Bleeding (Non-trauma)
Breathing Difficulty

**Background Information**

Breathing difficulty can occur anytime air flow or the exchange of oxygen and carbon dioxide is impaired. The body attempts to overcome this impairment by increasing the rate and depth of respirations. Paramedic evaluation and treatment may be critical to reverse the process that is occurring in the patient.

Critical factors that should have paramedic evaluation:

- Chest pain
- Inhaled substances
- Persons who are short of breath or cannot speak in full sentences because of respiratory distress
- Pulmonary embolism
- Children with asthma under the age of 12

Non-critical causes of breathing difficulty may be:

- Asthma (without any critical symptoms)
- Hyperventilation
- The common cold
- Bronchitis
- Drooling or difficulty swallowing associated with sneezing

Breathing difficulty may be an expression of an ongoing reaction and should always prompt further exploration associated with breathing.

**Work of Breathing:**

- Abnormal position, retractions, and audible breath sounds are signs of increased work of breathing and respiratory distress.

- **Tripod position:** Lean forward to breathe. This may improve breathing of the distressed child by aligning the structures of the airway.

- **Retractions:** Visible sinking in of the soft tissues in the chest wall or neck indicating a significant increased work of breathing.

- **Wheezes:** "Musical" high-pitched noises heard on exhalation. Often described as whistling and caused by bronchospasm or swelling of the large airways.

- **Stridor:** Harsh, high pitched sounds heard on inhalation. Caused by swelling of the upper airway.

**Hypoxemia:**

- Decreased oxygen saturation and caused by hypoxemia or hypoxic respiratory failure. Hypoxemia is described as a significant increased work of breathing.

- Anemia

**Critical factors that should have paramedic evaluation:**

- Children with asthma under the age of 12

**Non-critical causes of breathing difficulty may be:**

- Asthma (without any critical symptoms)
- Hyperventilation
- The common cold
- Bronchitis
- Drooling or difficulty swallowing associated with sneezing

**Work of Breathing:**

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**Dispatch Criteria**

**Medic Response**

<table>
<thead>
<tr>
<th>SM1</th>
<th>Unconscious or not breathing</th>
</tr>
</thead>
</table>
| SM2 | Respiratory Distress(one required):
| SM3 | Breathing difficulty with chest pain:
| SM4 | Male/Female, age > 25 |
| SM5 | Epi pen used by patient/RP |
| SM6 |  |
| SM7 |  |
| SM8 |  |

**BLS Red Response**

| SR1 | Breathing difficulty |
| SR2 | Tingling or numbness in extremities or around the mouth |
| SR3 | No verifiable info available from RP |
| SR4 | Breathing difficulty with barking cough, age <= 6 |
| SR5 | Hurts to breathe or pain with respiration |
| SR6 |  |

**BLS Yellow Response**

| SY1 | O₂ bottle empty |
| SY2 | Pepper spray |
| SY3 | Patient assist |
| SY4 | Hyperventilation/Panic Attack w/history of same |

| TRP |  |

**Vital Points**

- **Ask to speak directly to the patient, if possible!**
  - Medic: Is the patient able to speak in full sentences?
  - Does the patient have to sit up to breathe?
  - Does the patient have to lean forward to breathe?
  - Is the patient short of breath?
  - What was the patient doing just prior to when he/she became short of breath?
  - What substance did the patient inhale?
  - Could the patient be having an allergic reaction?
  - Is the patient drooling or having a difficult time swallowing?
  - If yes, is this causing breathing difficulty?
  - Is the patient on breathing treatment, or has he/she used it?
  - Has the patient ever had this problem before?

**BLS Red:**

- Does the patient feel pain? If yes, where is the pain located?
- Is the patient experiencing any other problems right now?

**BLS Yellow:**

- Is the patient on oxygen?

*Respiratory Infection Screening for Responder protection and advisement - *SEE PRE-ARRIVAL INSTRUCTION*"

**Pre-arrival Instructions**

- Keep patient calm.
- Patient may be more comfortable sitting up.
- Do not allow patient to exert him/herself.
- Gather patient meds, if possible.

*Respiratory Infection Screening - *Does the patient have a fever?*

- If unknown, are they hot to the touch?
- Does the patient have a cough?
- If yes, how long has the cough lasted?
- *Does the patient have a rash?*

**Short Report**

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response

*Advise Respiratory Protection*

- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

**5 Breathing Difficulty**
A state in which the heart fails to generate an effective blood flow to the body's vital organs. A patient in cardiac arrest will be unconscious, unresponsive and pulseless without adequate or effective respirations.

The causes of cardiac arrest are many and may include:
- Cardiovascular disease
- Cardiac Arrhythmia's
- Respiratory failure or arrest
- Trauma
- Drowning
- Electrocution

Critical symptoms of cardiac arrest:
- A sudden unconsciousness with absence of normal signs of life. (Normal breathing, coughing, movement)
- Agonal respiration's if the arrest is witnessed, frequently agonal or inadequate respiration's will be present. These may continue for several minutes.
- Agonal respirations may also be described. This brief period of activity is caused by the sudden interruption of oxygenated blood flow to the brain.

Agonal Respirations

The abnormal and inadequate respiratory effort commonly present in cardiac arrest is called agonal respirations. These respirations are being sent to the breathing muscles by the brainstem. They are typically slow, labored and often described as snoring, gasping, gurgling or moaning. It is very important to remember that these efforts are ineffective and by no means provide the patient with adequate exchange of oxygen.

Background Information

A state in which the heart fails to generate an effective blood flow to the body's vital organs. A patient in cardiac arrest will be unconscious, unresponsive and pulseless without adequate or effective respirations.
### Dispatch Criteria

<table>
<thead>
<tr>
<th>Dispatch Criteria</th>
<th>Medic Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>6M1</td>
<td>Unconscious or not breathing</td>
</tr>
</tbody>
</table>
| 6M2   | Obvious DOA:  
|       | • Cold/stiff, age < 1 yr. |

<table>
<thead>
<tr>
<th>BLS Red Response</th>
</tr>
</thead>
</table>
| 6R1   | Obvious DOA:  
|       | • Cold/stiff, age >= 1 yr.  
|       | • Decapitated  
|       | • Burned beyond recognition |
| 6R2   | Confirmed POLST order on premises |

### Vital Points

**Medic:**

If unsure about consciousness, use questions below to probe further:
- Does the patient respond to you?
  - Respond to your voice (can they answer your questions)
  - Respond when you try to wake them

If unsure about breathing normally, interrogate further:
- Does the patient's chest rise and fall?
- Describe the patient's breathing. Listen for sounds and frequency of breaths (agonal respirations described as):
  - gasping
  - snoring
  - snorting
  - gurgling
  - moaning
  - barely breathing
  - every once in awhile
  - takes breath now and then
  - occassional
  - weak or heavy

** If R/P cannot tell if the patient is breathing normally, assume the patient is not breathing normally, go directly to Cardiac/Respiratory arrest instructions, Section IV.

### Cardiac Arrest

- If unconscious, go directly to Unconscious/Breathing Normally - Airway Control (Non-trauma) Instructions, Section IV
- Cardiac/Respiratory Arrest instructions, Section IV. Determine appropriate age group.

### Short Report

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding
Background Information

Chest pain may be caused by many conditions, some of which are critical. Although it is often difficult to determine which calls are critical, some of the following information may be helpful.

**Critical causes of chest pain:**

- **Myocardial Infarction** occurs when a portion of the heart muscle is damaged due to lack of oxygenated blood flow to the heart muscle. Typically, the pain associated with myocardial infarction is described as a pressure, tightness, crushing or squeezing in the chest. Occasionally, there is no pain associated with a heart attack or there is only left arm or shoulder pain. Both history and associated symptoms may be helpful in making your decision.

- **Angina Pectoris** is chest pain which occurs because of a lack of blood flow to heart muscle. It is distinguished from myocardial infarction by its transitory nature and is usually relieved by rest and/or Nitroglycerin (NTG).

- **Supraventricular Tachycardias (SVT)** are a cause of rapid heart rates (RHR). The criteria for a MEDIC response is RHR’s/palpitations with history of same, with or without chest pain. There are many causes of rapid heart rates which are not critical incidents and require only BLS evaluation.

**Non-critical causes of chest pain include:**

- chest wall pain
- pleurisy
- esophageal reflux and/or spasm
- broken ribs
- costochondritis and pulled muscles

**Chest Pain Equivalents:**

The pain associated with Myocardial Infarction (heart attack) is typically described as a pressure, tightness, crushing or squeezing in the chest. Occasionally, there is no pain associated with a heart attack or there is only left arm or shoulder pain. Both history and associated symptoms may be helpful in making your decision.

- **Shortness of breath**
- **Diaphoresis**
- **Nausea**
- **Vomiting**
- **Radiation of pain to arms, jaw, neck, shoulder or back**
Dispatch Criteria

Medic Response

7M1 Unconscious or not breathing
7M2 Male, age >= 40
7M3 Female, age >= 45
7M4 Male/female, age > 25 with:
  • Shortness of breath
7M5 Rapid heart rate/palpitations with history of same, with or without chest pain
7M6 Signs of shock (two required):
  • Diaphoresis
  • Syncope/near syncope when sitting/standing
  • Pale, clammy skin • Nausea
7M7
7M8 Defib implant shock

BLS Red Response

7R1 Male, age < 40
7R2 Female, age < 45
7R3 Rapid heart rate/palpitations, without history
7R4 No verifiable info available from RP
7R5 Indigestion:
  • Male, age >= 40
  • Female, age >= 45

BLS Yellow Response

7Y1 Muscle/pectoral/rib pain

TRA

Pre-Arrival:

• Have patient sit or lie down.
• Keep patient calm.
• Is the patient taking nitroglycerin? (See Pre-Arrival Instructions)

Short Report:

• Has the patient ever had heart surgery or an MI?

Vital Points

• Ask to speak directly to the patient, if possible!

Medic:

• Where is the pain located?
• Does the patient feel pain anywhere else in the body?
• How long has the pain been present?
• Is the patient able to speak in full sentences?
• Is the patient short of breath?
• How does the patient look?
• How does the patient feel when he/she sits up?
• Is the patient nauseated or vomiting?
• Is the patient experiencing rapid heart rate?
• Does the patient have a history of rapid heart rate?

Chest Pain/Discomfort/Heart Problems

7R1 Male, age < 40
7R2 Female, age < 45
7R3 Rapid heart rate/palpitations, without history
7R4 No verifiable info available from RP
7R5 Indigestion:
  • Male, age >= 40
  • Female, age >= 45

7Y1 Muscle/pectoral/rib pain

TRA

Pre-Arrival:

• Have patient sit or lie down.
• Keep patient calm.
• Is the patient taking nitroglycerin? (See Pre-Arrival Instructions)

Short Report:

• Has the patient ever had heart surgery or an MI?

Pre-arrival Instructions

• Age
• Gender
• Chief complaint
• Dispatch criteria used to determine response
• Pertinent related symptoms
• Medical/surgical history, if relevant
• Other agencies responding

Short Report

• Chest pain/heart problems
• Indigestion
• Muscle/pectoral/rib pain

REVISED 05/04

7 Chest Pain/Heart
Choking is one of the most common causes of airway obstruction. You should consider choking anytime a person who has been eating is reported down or in a child under age 6.

Critical symptoms of choking:

Inability to talk - This suggests that the person is unable to move any air due to complete obstruction of the airway.

Cyanosis - This suggests that there is no air exchange due to complete obstruction of the airway.

If there is any suggestion of airway obstruction by the RP, the pre-arrival instructions for Choking should be accessed immediately.
### Dispatch Criteria

<table>
<thead>
<tr>
<th>Medic Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>8M1</td>
</tr>
<tr>
<td>8M2</td>
</tr>
<tr>
<td>8M3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BLS Red Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>8R1</td>
</tr>
<tr>
<td>8R2</td>
</tr>
<tr>
<td>8R3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BLS Yellow Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>8Y1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRP</th>
</tr>
</thead>
</table>

### Vital Points

- **Ask to speak directly to the patient, if possible!**
  - **Medic:**
    - Does the chest rise and fall?
    - Is the patient able to speak or cry?
    - Is the patient turning blue?
    - Was the person eating or did they have something in their mouth?
    - **If child is 6 years or below,**
      - Is the child hot to the touch?
    - If airway obstruction ruled out - go to PEDS card

### Choking

- **Short Report**
  - Age
  - Gender
  - Chief complaint
  - Dispatch criteria used to determine response
  - Pertinent related symptoms
  - Medical/surgical history, if relevant
  - Other agencies responding

- **Pre-arrival Instructions**
  - If unconscious, unable to speak or cry, go directly to **CHOKING Instructions, Section IV.** Determine appropriate age group.
  - If patient is able to exchange air (i.e. talk, cry):
    - Allow position of comfort;
    - Encourage coughing
Diabetes mellitus is a medical condition caused by decreased insulin production by the pancreas. It requires either oral medication or insulin injections to keep the blood sugar in a normal range. The diabetic that requires medication (either oral or insulin) is at great risk for developing a sugar level in the body that is either too high or too low. The brain responds to either with a decrease in the level of consciousness (LOC). The diabetic that requires medication (either oral or insulin) is at great risk for developing a sugar level in the body that is either too high or too low.

**Insulin shock** is the most frequent reason for accessing the 911 system for the diabetic. It occurs most often in the patient on Insulin (vs the oral medication) and results from an imbalance of too much insulin and not enough blood sugar. It can happen if the person does not eat enough, over exercises, takes too much insulin, has a fever, or is ill with nausea and vomiting. Insulin shock is usually of rapid onset.

**Ketoacidosis (Diabetic coma)*** is an accumulation of acids and ketone bodies in the blood. A ketone body is a by-product of fat metabolism. It occurs when there is not enough insulin to metabolize carbohydrates as energy. The body then uses fat as its primary source of energy, which results in the production of ketones (acetoacetate, beta-hydroxybutyrate) that build up in the blood and eventually pass into the urine. This condition can be life-threatening if not treated promptly with insulin.

**Hyperglycemia** is a greater than normal amount of glucose present in the blood. It is usually associated with diabetes. Hyperglycemia causes a variety of symptoms such as thirst, fatigue, and altered level of consciousness.}

**Hypoglycemia** is a deficiency of glucose present in the blood. It is usually associated with diabetes. Hypoglycemia can cause a variety of symptoms such as dizziness, sweating, and tremors of the body.
Medic Response

9M1 Unconscious or not breathing
9M2 Respiratory Distress (one required):
   • Sitting/leaning forward or standing to breathe
   • Speaks in short sentences
   • Noisy breathing
   • Pale and diaphoretic
   • Rapid, labored breathing
9M3 Decreased LOC or Uncooperative (Not following commands)
9M4 Signs of shock (three required):
   • Diaphoresis
   • Syncope/near syncope when sitting/standing
   • Pale, clammy skin
9M5 Chest pain
9M6
9M7 Seizure
9M8

BLS Red Response

9R1 Disoriented, unusual behavior or acting strange
9R2 Not feeling well, non-specific
9R3
9R4 No verifiable info available from RP
9R5

BLS Yellow Response

TRP

9T1 Awake/alert
9T2 Weakness

Diabetic

9  Diabetic

Pre-arrival Instructions

• Nothing by mouth, if patient unable to take it by him/her self.
• Give juice with sugar (2-3 tbsp.) if patient able to take by him/her self.
• Gather patient meds (If not done already). Test the patient's blood sugar, if you have the equipment and training to do this. Give the results to the aid crew when they arrive.

Short Report

• Age
• Gender
• Chief complaint
• Dispatch criteria used to determine response
• Pertinent related symptoms
• Medical/surgical history, if relevant
• Other agencies responding

Vital Points

• Ask to speak directly to the patient, if possible!

Medic:

• Is the patient able to speak in full sentences?
• Is the patient short of breath?
• Is the patient acting normal?
• If not, what is different?
• Can the patient respond to you and follow simple commands?
• Can the patient answer your questions?
• Does the patient know who he/she is and where they are?
• Does the patient take insulin?
• When did the patient last take their medication?
• When did the patient last eat?
• What is the patient's blood sugar level?
• How does the patient look?
• How does the patient feel when he/she sits up?
• Is the patient complaining of any pain?
• Has the patient had a seizure?

TRP:

• Is the patient feeling weak?
Environmental exposures may include exposure to excessive heat or cold or exposure to a hazardous material.

**Critical environmental emergencies:**
- **Hypothermia** results from prolonged cold exposure. It is relatively rare in King County, but may occur during a heat wave or result from prolonged exercise such as marathons or other athletic events during hot weather. Hypothermia may also occur in firefighters in the line of duty.

  In King County, cold exposure usually occurs in the transient population that has no housing, in the elderly that have no heat in their homes, and in water exposure particularly in Puget Sound this is a year-round occurrence. Initially, patients may be confused, disoriented or syncopal, and in extreme cold, exposure may result in cardiac arrest.

  Exposure to cold can result in a general cooling of the body that can go through the following stages:

  - Shivering - as the body attempts to generate heat
  - Feeling of numbness
  - Decreased LOC
  - Decreased muscle function
  - Decreased vital signs, slow pulse, respirations and heart rate
  - Freezing body parts (in extreme cold)

- **Hyperthermia** results from prolonged heat exposure. It is relatively rare in King County but may occur during a heat wave of prolonged exercise during hot weather. Hyperthermia may result in heat illnesses such as heat exhaustion or heat stroke.

  Hazardous material exposures may be quite dangerous and all responses are dependent upon the exposure and the danger that is involved from the chemical exposure.
Medic Response

**Dispatch Criteria**

- **10M1** Unconscious or not breathing
- **10M2** Respiratory Distress (one required):
  - Sitting/leaning forward or standing to breathe
  - Speaks in short sentences
  - Noisy breathing
  - Pale and diaphoretic
  - Rapid, labored breathing
- **10M3** Decreased LOC, disoriented
- **10M4** Signs of shock (three required):
  - Diaphoresis
  - Syncope/near syncope when sitting/standing
  - Pale, clammy skin

**Vital Points**

- Ask to speak directly to the patient, if possible!
  - **Medic:**
    - What happened?
    - Does the patient have any complaints?
    - Is the patient able to speak in full sentences?
    - Is the patient short of breath?
    - How does the patient look?
    - How does the patient feel when he/she sits up?
    - Can the patient respond to you and follow simple commands?
    - Can the patient answer your questions?
    - Is the patient acting normal? If not, what is different?

**Environmental Emergencies**

- **BLS Red Response**
  - **10R1** Chemical, (ingested or splashed on) w/o medic criteria
  - **10R2** Patient with uncontrollable shivering
  - **10R3** Patient excessively hot
  - **10R4** Other injuries
  - **10R5** No pertinent info available from RP
  - **10R6** Breathing difficulty

- **BLS Yellow Response**
  - **10Y1** Pepper spray

- **TRP**
  - **10T1** No symptoms, but has been exposed

**Pre-arrival Instructions**

- **Heat Exposure**
  - Loosen or remove clothing to assist in cooling.
  - Nothing by mouth.

- **Cold Exposure**
  - If patient is cold and dry, cover patient.
  - If patient is cold and wet, remove wet clothes and cover patient.
  - Nothing by mouth.

- **Chemical Exposure**
  - Do not touch patient.
  - Have patient remove contaminated clothing, if possible.
  - Continuously flush chemicals from eyes, remove contacts.
  - If chemical is powder, brush off, no water.
  - Get info on chemical (MSDS sheet if available).
  - Nothing by mouth.

**Short Report**

- **10  Environmental Emerg.**
  - **10M1** Unconscious or not breathing
  - **10M2** Respiratory Distress (one required):
    - Sitting/leaning forward or standing to breathe
    - Speaks in short sentences
    - Noisy breathing
    - Pale and diaphoretic
    - Rapid, labored breathing
  - **10M3** Decreased LOC, disoriented
  - **10M4** Signs of shock (three required):
    - Diaphoresis
    - Syncope/near syncope when sitting/standing
    - Pale, clammy skin
  - **10M5** Medical/surgical history, if relevant
  - **10M6** Other agencies responding

- **BLS Red:**
  - What was the source of the heat, cold or chemicals?

- **BLS Red: If not, what is different?**

- **BLS Yellow Response**
  - **10Y1** Pepper spray

- **TRP**
  - **10T1** No symptoms, but has been exposed

REVISED 09/04

10 Environmental Emerg.
Critical headaches are usually because of rapidly increasing pressure within the fixed volume that the skull provides to protect the brain. As the pressure increases within this fixed volume, the brain is compressed and neurologic deterioration begins.

Critical causes of headache:
- Subarachnoid hemorrhage is often caused by an aneurysm of one of the blood vessels that supply the brain. The aneurysm may begin leaking blood at any time, but is often precipitated by anything that elevates blood pressure, such as:
  - physical exertion
  - sexual intercourse
  - emotional anxiety

The patient usually complains of the worst headache they have ever experienced. They may display neurologic deterioration such as:
- mental confusion
- decreased LOC
- vertigo
- loss of balance or coordination
- weakness of one side of the body
- emotional anxiety
- sexual incontinence
- physical examination

Subarachnoid hemorrhage may occur in any age range but increased risk of cerebral hemorrhage in persons age 50 years or older. Aneurysms that supply the brain may be a hereditary condition found in as many as 2 of 1000 persons. Aneurysms may occur in any age range but subarachnoid hemorrhage may occur in any age range. Post-concussive headaches, which may occur after a minor head injury, are usually because of rapid increases in intracranial pressure resulting in neurologic deterioration. Noncritical causes of headaches include:
- post-concussive headaches
- tension headaches
- a history of similar symptoms
- syndrome of numbness and weakness, but generally have subtle neurologic symptoms, which may occur after a minor head injury
- migraine headaches

Intracerebral hemorrhage often has the same symptoms as subarachnoid hemorrhage but often occurs in an older population. Intracerebral hemorrhage may occur in any age range but intracerebral hemorrhage is often caused by an aneurysm or one of the blood vessels that supply the brain. Noncritical causes of headaches include:
- post-concussive headaches
- tension headaches
- migraine headaches

These headaches are usually because of rapid increases in intracranial pressure with the increased volume that the skull provides.
Dispatch Criteria

Medic Response

12M1 Unconscious or not breathing
12M2 Decreased LOC, disoriented
12M3
12M4
12M5
12M6
12M7 Sudden onset of severe headache, associated with any one of the following:
  - Slurred speech  •  Blurred/double vision
  - Weakness/paralysis  •  Diaphoresis
  - Vomiting

BLS Red Response

12R1 Disoriented, but able to talk and walk
12R2 No verifiable info available from RP
12R3 Minor head/neck injury
12R4 Visual difficulty
12R5 Vertigo
12R6

BLS Yellow Response

12Y1 Headache, after head injury, no medic criteria
12Y2 Minor mouth/facial injuries

TRP

12T1 Headache
12T2 Migraine(s)
12T3 Minor head/neck/facial pain
12T4 Eye, ear, nose, throat pain
12T5

Vital Points

• Ask to speak directly to the patient, if possible!

Medic:
• Did the headache come on suddenly or gradually?
• Does the patient have any vision problems?
• Can the patient respond to you and follow simple commands?
• Can the patient answer your questions?
• Does the patient know where he/she is and who he/she is?
• Is the headache different than headaches the patient has had in the past?
• What was the patient doing when the headache started?
• How is the patient acting? If unusual, what is different about them?
• How does the patient look?

TRP:
• Has the patient had a recent illness or injury?
• Does the patient have a history of headaches?

Short Report:
• Is the patient wearing a Medic Alert tag?

Pre-arrival Instructions

• Nothing by mouth.
  • Allow patient to find position of comfort.
  • If nosebleed, pinch end of nose and do not release
  • Gather patient meds.

Head/Neck

Short Report

• Age
  • Gender
  • Chief complaint
  • Dispatch criteria used to determine response
  • Pertinent related symptoms
  • Medical/surgical history, if relevant
  • Other agencies responding

12 Head/Neck
Very few mental or emotional problems are a critical medical problem unless the patient is threatening to harm him/herself or others. However, sometimes it is very difficult to distinguish a mental/emotional problem from a medical problem. For example, sometimes it is very difficult to tell whether a patient is premeditating to harm him/herself or is just exhibiting unusual behavior with a psychiatric history.

Critical responses in mental/emotional patient:
- Penetrating wounds that are self-inflicted above the hands
- Overdose in the suicidal patient
- Diabetic patients with hypoglycemia or insulin shock may present as a mental/emotional problem.

Noncritical responses may include:
- Lacerated wrists with controlled bleeding
- Street drug intoxication or ingestion
- Arousable alcohol intoxication
- Unusual behavior with a psychiatric history
- Acute allergic reaction
- Successful suicide attempt or ingestion

Mental/Emotional/Psychological

Noncritical responses may include:
- Overdose in the suicidal patient
- Diabetic patients with hypoglycemia or insulin shock may present as a mental/emotional problem.
- Arousable alcohol intoxication
- Unusual behavior with a psychiatric history
- Unusual behavior with a psychiatric history
- Acute allergic reaction
- Successful suicide attempt or ingestion

Critical responses in the mental/emotional patient:
- Penetrating wounds that are self-inflicted above the hands
- Overdose in the suicidal patient
- Diabetic patients with hypoglycemia or insulin shock may present as a mental/emotional problem.

Noncritical responses may include:
- Lacerated wrists with controlled bleeding
- Street drug intoxication or ingestion
- Arousable alcohol intoxication
- Unusual behavior with a psychiatric history
- Unusual behavior with a psychiatric history
- Acute allergic reaction
- Successful suicide attempt or ingestion
## Vital Points

- Ask to speak directly to the patient, if possible!

  **Medic:**
  - What happened?
  - Is the scene secure?
  - Is the suspect in the area? If yes, get description.
  - Does the patient have a weapon or access to a weapon?
  - Has the patient harmed him/herself?
    - If yes, with what?
    - What are the injuries?
    - What part of the body is injured?

  **Pre-arrival Instructions**
  - Keep patient in area, if safe.
  - Keep patient calm.
  - If you feel you are in danger, leave the scene.
  - Gather patient meds.

## Mental/Emotional/Psychological

- DANGER TO FIELD UNITS, IF PRESENT INCLUDE SUSPECT/VEHICLE DESCRIPTION
  - Age • Gender • Chief complaint
  - Dispatch criteria used to determine response
  - Pertinent related symptoms
  - Medical/surgical history, if relevant
  - Other agencies responding

## Dispatch Criteria

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>13M1</td>
<td>Unconscious or not breathing</td>
</tr>
<tr>
<td>13M2</td>
<td>Suicide attempt with GSW, stabbing, crushing or penetrating injury above hands or feet</td>
</tr>
<tr>
<td>13M3</td>
<td></td>
</tr>
</tbody>
</table>

## BLS Red Response

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>13R1</td>
<td>Self-inflicted injuries</td>
</tr>
<tr>
<td>13R2</td>
<td>Unusual behavior</td>
</tr>
<tr>
<td>13R3</td>
<td>Panic attack, unknown history</td>
</tr>
<tr>
<td>13R4</td>
<td></td>
</tr>
<tr>
<td>13R5</td>
<td>No verifiable info available from RP</td>
</tr>
</tbody>
</table>

## BLS Yellow Response

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>13Y1</td>
<td>Police request for stand-by, threats against self or others</td>
</tr>
<tr>
<td>13Y2</td>
<td>Pepper Spray or Taser</td>
</tr>
<tr>
<td>13Y3</td>
<td>Patient assist</td>
</tr>
<tr>
<td>13Y4</td>
<td>Panic attack with known history (hyperventilation)</td>
</tr>
<tr>
<td>13T1</td>
<td>Patient out of psych medications</td>
</tr>
</tbody>
</table>

## Short Report

- Age • Gender • Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding
Background Information

Many types of medications are central nervous system depressants. These include:

- **Narcotic medications**: heroin, morphine, methadone, Demerol, Tylox, Percodan, and codeine
- **Sedative medications**: Valium, Librium, all barbiturates, sleeping pills, tranquilizers or "downers"
- **Tricyclic antidepressants**: Elavil, Sinequan, Asendin, Desyrel, Ludiomil, Norpramin, Tofranil, Triavil, and Vivactil

These medications suppress the respirations of the patient, who may become comatose very rapidly following ingestion, and necessitate a MEDIC response.

Cocaine and other CNS stimulants such as amphetamines may cause symptoms of excitability, increased blood pressure, irritability or cardiac complaints.

Critical overdoses or poisonings:

- Intentional/Suicidal overdose with a prescription medication.
- Respiratory distress or difficulty swallowing following any ingestion.
- Chemical ingestion with household cleaners, antifreeze, methanol, solvents or cyanide.
- Alcohol (ETOH) intoxication in the younger patient may be critical because of their tendency to rapidly ingest large amounts over a very short period of time causing rapid loss of consciousness.
- Combined alcohol and drug overdose.
- Acute ETION intoxication in the young patient may be critical.
- Chemical ingestion with household cleaners, antifreeze.

Resources:

Poison Control - 526-2121. Responding unit should call Poison Control directly, when possible.

Responding unit evaluated by a EMT unit for return to a medical facility. These usually do not require MEDIC response but should be evaluated by the Poison Control Center, which can provide information on medication effects, antidotes and treatment guidelines.

Resources:

- Toxicology information: EMT, Pharmacist, Emergency Room, Poison Control Center.
- Poison Control Center: 526-2121.

Many types of medications are central nervous system depressants. These include:

- Narcotic medications: heroin, morphine, methadone, Demerol, Tylox, Percodan, and codeine
- Sedative medications: Valium, Librium, all barbiturates, sleeping pills, tranquilizers or "downers"
- Tricyclic antidepressants: Elavil, Sinequan, Asendin, Desyrel, Ludiomil, Norpramin, Tofranil, Triavil, and Vivactil

Combined alcohol and drug overdose:

- Acute ETION intoxication in the young patient may be critical.
- Combined alcohol and drug overdose.
- Chemical ingestion with household cleaners, antifreeze.

Resources:

- Poison Control - 526-2121.
- Responding unit should call Poison Control directly, when possible.

Responding unit evaluated by a EMT unit for return to a medical facility. These usually do not require MEDIC response but should be evaluated by the Poison Control Center, which can provide information on medication effects, antidotes and treatment guidelines.

Resources:

- Toxicology information: EMT, Pharmacist, Emergency Room, Poison Control Center.
- Chemical inestrogen: EMT, Pharmacist, Emergency Room, Poison Control Center.
- Poison Control Center: 526-2121.

Many types of medications are central nervous system depressants. These include:

- Narcotic medications: heroin, morphine, methadone, Demerol, Tylox, Percodan, and codeine
- Sedative medications: Valium, Librium, all barbiturates, sleeping pills, tranquilizers or "downers"
- Tricyclic antidepressants: Elavil, Sinequan, Asendin, Desyrel, Ludiomil, Norpramin, Tofranil, Triavil, and Vivactil

Combined alcohol and drug overdose:

- Acute ETION intoxication in the young patient may be critical.
- Combined alcohol and drug overdose.
- Chemical ingestion with household cleaners, antifreeze.
**Dispatch Criteria**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>14M1</td>
<td>Unconscious or not breathing</td>
</tr>
<tr>
<td>14M2</td>
<td>Respiratory Distress (one required):</td>
</tr>
<tr>
<td></td>
<td>• Sitting/leaning forward or standing to breathe</td>
</tr>
<tr>
<td></td>
<td>• Speaks in short sentences</td>
</tr>
<tr>
<td></td>
<td>• Noisy breathing • Pale and diaphoretic</td>
</tr>
<tr>
<td></td>
<td>• Rapid, labored breathing</td>
</tr>
<tr>
<td>14M3</td>
<td>Decreased LOC/disoriented-excluding alcohol consump-</td>
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<td></td>
<td>tion</td>
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<tr>
<td>14M4</td>
<td>Intentional/accidental, with Rx meds &lt; 2 hrs. since</td>
</tr>
<tr>
<td></td>
<td>ingestion</td>
</tr>
<tr>
<td>14M5</td>
<td>Ingestion of caustic substance, w/ difficulty swallowing</td>
</tr>
<tr>
<td>14M6</td>
<td>Acute alcohol intoxication (unresponsive)</td>
</tr>
<tr>
<td></td>
<td>• Age &lt; 17, and/or</td>
</tr>
<tr>
<td></td>
<td>• Combined alcohol and drugs, any age</td>
</tr>
<tr>
<td>14M7</td>
<td>Seizure, secondary to alcohol and/or drug overdose, use</td>
</tr>
<tr>
<td></td>
<td>or withdrawals</td>
</tr>
<tr>
<td>14M8 - 14M9</td>
<td></td>
</tr>
<tr>
<td>14M10</td>
<td></td>
</tr>
</tbody>
</table>

**BLS Red Response**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14R1</td>
<td>Intentional/accidental, with over-the-counter (OTC) medicines</td>
</tr>
<tr>
<td>14R2</td>
<td>No verifiable info available from RP</td>
</tr>
<tr>
<td>14R3</td>
<td>Reported O.D., patient denies taking meds, or unknown if meds/substances were taken</td>
</tr>
<tr>
<td>14R4</td>
<td>Chemicals (ingested or splashed on) w/o medic criteria</td>
</tr>
<tr>
<td>14R5</td>
<td>Intentional/accidental with Rx meds &gt; = 2 hrs. since ingestion</td>
</tr>
<tr>
<td>14R6</td>
<td>Breathing difficulty</td>
</tr>
<tr>
<td>14R7</td>
<td>Combined alcohol and drugs (responsive)</td>
</tr>
</tbody>
</table>

**BLS Yellow Response**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14Y1</td>
<td>Known alcohol intoxication w/out other drugs (responsive)</td>
</tr>
<tr>
<td>14Y2</td>
<td>Street drugs</td>
</tr>
<tr>
<td>14Y3</td>
<td>Pepper spray or Taser</td>
</tr>
<tr>
<td>14T1</td>
<td>No symptoms, but has been exposed</td>
</tr>
</tbody>
</table>

**Vital Points**

- Ask to speak directly to the patient, if possible!
- Medic:
  - Can the patient speak in full sentences?
  - Is the patient short of breath?
  - Can the patient respond to you and follow simple commands?
  - Can the patient answer your questions?
  - Is the patient having difficulty swallowing?
  - What type of substance did the patient take?
    - Was alcohol involved?
    - If yes, what age is the patient?
    - Recreational drugs?
    - If yes, what kind?
    - Prescription Meds?
    - If yes, what kind and how many?
  - Has the patient had a seizure?

**BLS Red:**

- If the patient took medications, were they prescription medications?
  - If yes, how many?
  - How long ago did they ingest the substance?

**Short Report:**

- Is the patient violent? Access to a weapon?
- Is the patient acting normal? If not what is different?
- Has the patient vomited?

**Pre-arrival Instructions**

- Keep patient in area/house if safe.
- Retrieve container of substance taken.
- Don’t place patient in bath or shower.
- If unconscious, go directly to Unconscious/Breathing Normally - Airway Control (Non-trauma) instructions, Section IV
- Nothing by mouth.
- Gather patient meds.

**Short Report**

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding
Since pregnancy and childbirth is a natural process and not a medical illness, a normal delivery takes place most of the time. A MEDIC response should be sent for all imminent deliveries, not only to render assistance to the mother but to the newborn infant. Breaking of a woman’s water may signify that labor is imminent but does not signify that delivery is imminent. A MEDIC response is also indicated for the unusual or problematic delivery or problems that develop during the last trimester of pregnancy.

**Critical problems:**

- **Eclampsia or pre-eclampsia** is a toxic state that develops in the last trimester. It is characterized by increased blood pressure, fluid retention, and seizures (if very severe).

- **Vaginal bleeding in a pregnancy > 20 weeks** can be dangerous because of the rapid blood loss through the placenta. Often this is associated with **placenta previa**, a condition where the placenta partially or completely blocks the cervix.

- **Abruptio placentae** occurs when the placenta separates prematurely from the uterine wall and results in bleeding from the site, usually as a result of trauma. Shock can ensue rapidly.

- **Abdominal injury with contractions in a pregnancy > 20 weeks** should be a MEDIC response since any pregnancy > 20 weeks carries some chance of fetal survival if delivery occurs.

**Noncritical situations or symptoms include:**

- **Breech delivery** - when the presenting part of the baby is the back, buttocks, or legs, which may require medical intervention.

- **Premature** < 4 weeks: An increased risk of complications and a higher risk of death for both the mother and the baby may require medical intervention.

- **Complication or intervention during a delivery:**
  - Sepsis: Severe and life-threatening infection.
  - Prolonged labor: More than 24 hours.
  - Shoulder dystocia: Difficulty delivering the baby's shoulders.
  - Severe postpartum hemorrhage: Excessive bleeding after delivery.

**Prematurity > 4 weeks** suggests that the delivery may be more complicated and that the baby may need more intervention.

**Breech delivery** - when the presenting part of the baby is anything but the head.

**Prolapsed cord** - when the umbilical cord is born first before the baby, possibly cutting off oxygen to the baby.

**Noncritical situations or symptoms include:**

- **Abdominal injury without contractions**
- **Abdominal injury in a pregnancy < 20 weeks**
- **Abdominal pain**
- **Vaginal bleeding/cramping in a pregnancy > 20 weeks**
- **Abdominal pain in a pregnancy > 20 weeks**
- **Abdominal pain without contractions**
- **Abdominal pain with contractions in a pregnancy > 20 weeks**
- **Labor pains or contractions < 2 minutes between contractions or in a 2nd pregnancy < 5 minutes between contractions**

**Prematurity > 4 weeks** suggests that the delivery may be more complicated and that the baby may need more intervention.
Dispatch Criteria

Medic Response

Vital Points

Pre-arrival Instructions

Pregnancy/Childbirth/GYN

15M1 Unconscious or not breathing
15M2 Pregnant with heavy vaginal bleeding (soaked 3 pads/hr) with one or more signs of shock
15M3 Signs of shock (three required):
  • Diaphoresis • Pale, clammy skin • Nausea
  • Syncope/near syncope when sitting/standing
15M4 Labor pains/contractions:
  • 1st preg., < 2 mins. between contractions
  • 2nd preg., < 5 min. between contractions
  • Prior delivery with labor lasting < 1 hr.
15M5 Bleeding > 20 weeks pregnant
15M6 Complications: Breech, abnormal presentation
15M7 Delivery
15M8 Abdominal injury, with contraction, > 20 weeks
15M9 Seizure: • > 20 weeks pregnant

BLS Red Response

BLS Yellow Response

TRP

15R1 Vaginal bleeding
15R2 1st pregnancy with > 2 mins. between contractions
15R3 2nd pregnancy with > 5 mins. between contractions
15R4 Abdominal injury, w/o contractions, > 20 weeks pregnant
15R5 Water broke, with contractions
15R6 No verifiable info available from RP

15T1 Pregnant < 20 weeks or menstrual, with any of the following:
  • Cramps • Pelvic Pain • Spotting
15T2 Water broke, no contractions

Medic:
• Ask to speak directly to the patient, if possible!
  • Is she bleeding?
  • If yes, how many pads an hour?
  • How does the patient look?
  • How does she feel when she sits up?
  • How long has she been having contractions?
  • How many minutes between the beginning of one contraction to the beginning of the next?
  • Is this the first pregnancy?
  • How far along is she?
  • Was there an injury?
  • Does she feel the urge to have a bowel movement?
  • If post delivery, is the baby breathing?

BLS Red:
• Has she had any problems during pregnancy?

Short Report

• Age
• Gender
• Chief complaint
• Dispatch criteria used to determine response
• Pertinent related symptoms
• Medical/surgical history, if relevant
• Other agencies responding

• Do not let patient go to toilet.
• Have patient lie down on left side.
• Keep patient warm.
• Gather patient meds.
• Gather clean clothes or towels
• If childbirth is imminent (baby is crowning) labor pains / contraction and delivery, go directly to Childbirth Instructions, Section IV.
Seizures are the result of uncontrolled electrical activity in the brain causing all circuits to fire resulting in seizure activity, loss of consciousness and no breathing. Febrile seizures occur commonly in children < age 6, are usually short in duration, grand mal (generalized body convulsions) and stop spontaneously w/out intervention. Seizures in children < age 6 are assumed febrile seizures unless they meet any of the critical criteria listed below.

**Critical Seizure Criteria for MEDIC Response:**

- Seizures lasting > 5 minutes or multiple seizures
- Seizures accompanied by loss of consciousness
- Seizures in children under 6 years of age
- Seizures accompanied by head trauma
- Seizures in pregnant women
- Seizures in diabetic patients
- Seizures in patients with recent head trauma
- Seizures in patients with diabetes
- Seizures in patients with hypertension

Seizures in diabetic patients usually result from hypoglycemia and should have immediate correction of their blood sugar level. Febrile seizures in children < age 6 are usually not due to hypoglycemia, but rather due to febrile illness.

Seizures in children < age 6 are assumed febrile seizures unless they meet any of the critical criteria listed below. Seizures in children < age 6 are usually short in duration, grand mal (generalized body convulsions) and stop spontaneously w/out intervention. Seizures in children < age 6 are assumed febrile seizures unless they meet any of the critical criteria listed below.

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- Seizures in patients with recent head trauma
- Seizures in patients with diabetes
- Seizures in patients with hypertension

Seizures in diabetic patients usually result from hypoglycemia and should have immediate correction of their blood sugar level.
### Dispatch Criteria

<table>
<thead>
<tr>
<th>16M1</th>
<th>Not breathing after seizure stops</th>
</tr>
</thead>
<tbody>
<tr>
<td>16M2</td>
<td>Extended seizure, &gt; 5 minutes</td>
</tr>
<tr>
<td>16M3</td>
<td>Multiple seizures, &gt; 3 per hour</td>
</tr>
<tr>
<td>16M4</td>
<td>Severe headache, prior to seizure</td>
</tr>
<tr>
<td>16M5</td>
<td>Diabetic</td>
</tr>
<tr>
<td>16M6</td>
<td>Pregnant &gt; 20 weeks</td>
</tr>
<tr>
<td>16M7</td>
<td>Seizure secondary to alcohol and/or drug overdose, use or withdrawals</td>
</tr>
<tr>
<td>16M8</td>
<td>Secondary to head injury within the last 24 hours.</td>
</tr>
<tr>
<td>16M9</td>
<td></td>
</tr>
</tbody>
</table>

### Medic Response

**Vital Points**

- Ask to speak directly to the patient, if possible!
- **Medic:**
  - How long has the patient been seizing?
  - Is the patient still seizing?
  - Has the patient had a seizure before?
  - Is the patient a diabetic?
  - If female, is the woman pregnant? **If yes,** how many weeks pregnant?
  - Has the patient taken any:
    - Drugs?
    - Alcohol?
    - Medications?
  - Has the patient had a recent head injury? **If yes,** when?

### Pre-arrival Instructions

- Move anything away from patient that patient could be hurt by striking.
- Do not restrain patient.
- Do not place anything in patient's mouth.
- After seizure has stopped, assess breathing.
- Have patient lie on side.
- If peds seizure, remove clothing to cool patient.
- If unconscious after seizure, go directly to **Unconscious/Breathing Normally - Airway Control (Non-trauma)**, Section IV.
- Gather patient meds.

### Seizures

<table>
<thead>
<tr>
<th>16R1</th>
<th>First-time seizure</th>
</tr>
</thead>
<tbody>
<tr>
<td>16R2</td>
<td>Single seizure with history of seizure disorder</td>
</tr>
<tr>
<td>16R3</td>
<td>Seizure, unknown history</td>
</tr>
<tr>
<td>16R4</td>
<td>No verifiable information from RP</td>
</tr>
<tr>
<td>16R5</td>
<td>Seizure aura</td>
</tr>
<tr>
<td>16R6</td>
<td></td>
</tr>
</tbody>
</table>

### Short Report

- Is the patient wearing a Medic Alert tag?

### BLS Red Response

<table>
<thead>
<tr>
<th>16R1</th>
<th>First-time seizure</th>
</tr>
</thead>
<tbody>
<tr>
<td>16R2</td>
<td>Single seizure with history of seizure disorder</td>
</tr>
<tr>
<td>16R3</td>
<td>Seizure, unknown history</td>
</tr>
<tr>
<td>16R4</td>
<td>No verifiable information from RP</td>
</tr>
<tr>
<td>16R5</td>
<td>Seizure aura</td>
</tr>
<tr>
<td>16R6</td>
<td></td>
</tr>
</tbody>
</table>

### BLS Yellow Response

<table>
<thead>
<tr>
<th>TRP</th>
</tr>
</thead>
</table>

### Short Report

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding
Background Information

The Sick (unknown) category must be used for the calls that are received that have no specific complaint or do not fall under other categories.

High blood pressure or high temperature without other critical symptoms is not a life-threatening condition.

The Sick (unknown) category must be used for the calls that are received that have no specific complaint or do not fall under other categories.
**Dispatch Criteria**

**Medic Response**
- 17M1 Unconscious or not breathing
- 17M2 Decreased LOC, disoriented
- 17M3
- 17M4 Rapid heart rate with history of same, with or without chest pain.
- 17M5 Signs of shock (two required):
  - Diaphoresis
  - Syncope/near syncope when sitting/standing
  - Pale, clammy skin
  - Nausea

**BLS Red Response**
- 17R1 Vertigo
- 17R2 Generalized weakness
- 17R3 No verifiable info available from RP
- 17R4 Medical alarm company, confirmed medical emergency
- 17R5 Other
- 17R6
- 17R7

**BLS Yellow Response**
- 17Y1 Generalized/unspecified pain
- 17Y2
- 17Y3 Patient Assist
- 17Y4 Hang up Call-Consider PD Response
- 17Y5 Med alarm, confirmed noncritical or no information

**TRP**
- 17T1 Flu symptoms (any one): • Nausea • Vomiting
  • Chills • Sore throat • Cough • Headache
- 17T2 High blood pressure w/o specific symptoms
- 17T3 Temperature/Fever
- 17T4 Other

**Vital Points**
- Ask to speak directly to the patient, if possible!
- **Medic:**
  - How does the patient feel when he/she sits up?
  - How does the patient look?
  - Describe what the patient is doing?
  - What is the patient complaining of?
  - Can the patient respond to you and follow simple commands?
  - Can the patient answer your questions?
  - Is the patient acting normal? If not, what is different?
  - Is the patient complaining of pain? Where?

**Respiratory Infection Screening - SEE PRE-ARRIVAL INSTRUCTIONS**

- *Does the patient have a fever?*
  - If unknown, are they hot to the touch
- *Does the patient have a cough?*
  - If yes, how long has the cough lasted?
- *Does the patient have a rash?*

**Short Report**
- *If patient is not a family member:
  Have you checked for a Medic Alert tag?*
- Have you checked in the refrigerator for Insulin?

**Sick (Unknown)/Other**
- Keep patient warm.
- Position of comfort.
- Gather patient meds.

**Respiratory Infection Screening:**
- *Does the patient have a fever?*
  - If unknown, are they hot to the touch
- *Does the patient have a cough?*
  - If yes, how long has the cough lasted?
- *Does the patient have a rash?*

**Short Report**
- *Age
  - Gender
  - Chief complaint
  - Dispatch criteria used to determine response

**Pre-arrival Instructions**
- *Advise Respiratory protection*
  - Pertinent related symptoms
  - Medical/surgical history, if relevant
  - Other agencies responding

**17M1 Unconscious or not breathing**

**17M2 Decreased LOC, disoriented**

**17M3**

**17M4 Rapid heart rate with history of same, with or without chest pain.**

**17M5**

**Signs of shock (two required):**
- Diaphoresis
- Syncope/near syncope when sitting/standing
- Pale, clammy skin
- Nausea

**17R1 Vertigo**

**17R2 Generalized weakness**

**17R3 No verifiable info available from RP**

**17R4 Medical alarm company, confirmed medical emergency**

**17R5 Other**

**17R6**

**17R7**

**17Y1 Generalized/unspecified pain**

**17Y2**

**17Y3 Patient Assist**

**17Y4 Hang up Call-Consider PD Response**

**17Y5 Med alarm, confirmed noncritical or no information**

**17T1 Flu symptoms (any one):**
- Nausea
- Vomiting
- Chills
- Sore throat
- Cough
- Headache

**17T2 High blood pressure w/o specific symptoms**

**17T3 Temperature/Fever**

**17T4 Other**

**REVISED 05/04**
A stroke or cerebrovascular accident (CVA) may be a simple dysphonia or a simple transient ischemic attack (TIA). A stroke may be so extensive as to create severe brain dysfunction, seizures or severe headache. A stroke may present as decreased LOC or respiratory difficulty. Many stroke victims have difficulty speaking and may present with additional symptoms similar to those of decreased LOC or symptoms of a stroke. Common symptoms associated with a CVA include:

- Difficulty speaking
- Decreased LOC
- Respiratory difficulty
- Seizures
- Severe headache
- Speech difficulty
- Decrease in LOC
- Respiratory difficulty
- Seizures
- Severe headache

In summary, most strokes or CVAs do not require a MEDIC response, but you should be aware of the critical symptoms and signs that are associated with a CVA. Critical instances:

- Rupture of an artery or an aneurysm may occur in the brain tissue and present as a stroke with additional symptoms of decreased LOC, respiratory difficulty, seizures or severe headache.
- A stroke may be so extensive as to create severe brain dysfunction, seizures or severe headache. In summary, most strokes or CVAs do not require a MEDIC response, but you should be aware of the critical symptoms and signs that are associated with a CVA.
### Dispatch Criteria

#### Medic Response
- **18M1** Unconscious or not breathing
- **18M2** Sudden onset of severe headache (not migraine), associated with one of the following:
  - Slurred speech
  - Blurred/double vision
  - Weakness/paralysis
  - Diaphoresis
  - Vomiting
- **18M3** Decreased LOC, disoriented with Respiratory distress: (one required)
  - Sitting/leaning forward or standing to breathe.
  - Speaks in short sentences
  - Noisy breathing
  - Pale and diaphoretic
  - Rapid, labored breathing
- **18M4**
- **18M5**
- **18M6** Diabetic

#### BLS Red Response
- **18R1** Unilateral (one-sided)
- **18R2** Weakness, numbness or unable to stand or walk
- **18R3**
- **18R4** Breathing difficulty
- **18R5** No verifiable info available from RP
- **18R6** Disoriented, incoherent or trouble speaking

#### BLS Yellow Response

### Vital Points
- **Pre-arrival Instructions**
  - Ask to speak directly to the patient, if possible!

**Medic:**
- Has the patient had a headache?
- Is the patient’s speech slurred?
- Can the patient respond to you and follow simple commands?
- Can the patient answer your questions?
- If acting unusual, what is different?
- Is the patient short of breath?
- Is the patient a diabetic?
- Is the patient complaining of any pain?

**BLS:**
- How does the patient look?

**Short Report:**
- Does the patient have any other medical or surgical history?

### Stroke (CVA)

#### Pre-arrival Instructions
- Keep patient calm.
- Don’t allow patient to move around.
- Keep neck straight (remove pillows).
- Nothing by mouth.
- Gather patient meds.

#### Short Report
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding
Background Information
Unconscious/Unresponsive is another category that does not have a diagnostic differential easily available. This is a frequent illness that can be life-threatening. You will often need to re-weigh the illness or problems shown up in other categories. Use your critical symptoms to formulate your dispatch plan rather than looking for a diagnosis.

Unconscious/Unresponsive/Syncope
**Dispatch Criteria**

<table>
<thead>
<tr>
<th>Medic Response</th>
<th>Vital Points</th>
<th>Unconscious/Unresponsive/Syncope</th>
<th>Pre-arrival Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unconscious</strong></td>
<td>• Ask to speak directly to the patient, if possible!</td>
<td></td>
<td>• Unconscious/Breathing Normally - Airway Control (Non-trauma) instructions, Section IV</td>
</tr>
<tr>
<td><strong>Unconscious</strong></td>
<td>• Does the patient respond to you?</td>
<td></td>
<td>• If conscious now, have patient lie down.</td>
</tr>
<tr>
<td><strong>Acute alcohol intoxication</strong></td>
<td>• Respond to your voice (can they answer your questions)</td>
<td></td>
<td>• If patient vomiting, have patient lie on side.</td>
</tr>
<tr>
<td><strong>Respiratory Distress</strong></td>
<td>• Respond when you try to wake them</td>
<td></td>
<td>• Do not leave patient, be prepared to do CPR.</td>
</tr>
<tr>
<td><strong>Syncope</strong></td>
<td>• Is this the first time today the patient has been unconscious?</td>
<td></td>
<td>• Gather patient meds, if possible.</td>
</tr>
<tr>
<td><strong>Syncope</strong></td>
<td>• What was the patient doing before they became unconscious?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Syncope</strong></td>
<td>• Did the patient have any complaints just before he/she became unconscious?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Syncope</strong></td>
<td>• Has the patient taken any medications, recreational drugs or alcohol?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Syncope</strong></td>
<td>• Is the patient short of breath?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Syncope</strong></td>
<td>• Is the patient able to speak in full sentences?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Syncope</strong></td>
<td>• How does the patient feel when he/she sits up?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Syncope</strong></td>
<td>• Is the patient experiencing a rapid heart rate/palpitations?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Syncope</strong></td>
<td>• Is the patient experiencing pain/discomfort? Where?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BLS Red Response**

| 19R1 UNCONFIRMED unconscious |
| 19R2 Multiple syncopal episodes (same day) |
| 19R3 No verifiable info available from RP |
| 19R4 Single syncope |
| 19R5 Combined alcohol and drugs (responsive) |
| 19R6 |
| 19R7 |
| 19R8 Alcohol intoxication without medic criteria |

**BLS Yellow Response**

| 19Y1 Slumped over wheel-Consider PD response |
| 19Y2 Known alcohol intoxication w/out other drugs (responsive) |

**TRP**

| 19T1 Near syncope |
| 19T2 Conscious, with minor injuries |

**Short Report**

| 19 Uncons/Syncope |

**Short Report**

| 19 Uncons/Syncope |

**Short Report**

| 19 Uncons/Syncope |

**Short Report**

| 19 Uncons/Syncope |
Background Information

Obtaining information in the case of a pediatric patient can be challenging. In most cases, the patient is too young to be able to complain of pain or describe symptoms they may be experiencing. Additionally, small children do not present with the common progression of illnesses or shock as adults do, often making the early recognition of critical signs difficult to detect. For these reasons, the EMS community has adopted what is commonly referred to as the “pediatric triangle” for making a rapid determination of the pediatric patient’s status. The three components of this triangle are: OVERALL APPEARANCE, WORK OF BREATHING and CIRCULATION/SKIN SIGNS. Don’t rely on the traditional measurement of vital signs, such as pulse rate and blood pressure, to identify an unstable patient. Because this evaluation is primarily visual, it could be easily assessed with the vital point questions and a cooperative RP.

APPEARANCE:

Appearance tells a lot about oxygenation, brain perfusion and central nervous system function. There are several components that constitute appearance:

• Alertness: Is the child responsive? Restless, agitated or listless?
• Distractibility: Are you able to attract child’s interest or attention?
• Consolability: Can parent or caregiver comfort child?
• Eye contact: Does child maintain eye contact?
• Speech/Cry: Is speech/cry strong? Weak or muffled? Hoarse?
• Spontaneous motor activity: Is child moving? Is there good muscle tone?
• Color: Is the child pink? Or pale, dusky or mottled?

WORK OF BREATHING:

Abnormal position, retractions and audible breath sounds are signs of increased work of breathing and respiratory distress.

• Tripod position: Leaning forward to breathe? This may improve breathing of the distressed child by aligning the structures of the airway.
• Retractions: Visible sinking in of the soft tissues in the chest wall or neck indicating a significant increased work of breathing.
• Wheezes: “Musical” high-pitched noises heard on exhalation. Often described as whistling and caused by bronchospasm or swelling of the large airways.
• Stridor: Harsh, high pitched sounds heard on inhalation. Caused by swelling and spasms of the upper airways.

CIRCULATION/SKIN SIGNS:

Skin signs are a direct reflection of the overall status of the circulatory system.

• Skin Color: Is it normal? Pink? Mottled, pale, grayish? Cyanosis is a late finding and should not be relied upon as the only determination of an ill child.
• Temperature: Is it normal? Hot? Cool?
• Capillary Refill Time: A very accurate way to determine the circulatory status in any patient. Depress the fingertip and the pink color should return in less than 2 seconds. Any slower may indicate a problem with perfusion.

FEBRILE SEIZURES:

Febrile seizures occur commonly in children < age 6, are usually short in duration, grand mal (generalized body convulsions) and stop spontaneously without intervention. Seizures in children < age 6 are assumed febrile seizures.
Medic Response

Vital Points

Pre-arrival Instructions

Pediatric Emergencies

Dispatch Criteria

Medic Response
20M1 Unconscious/unresponsive: Listless, limp
20M2 Able to awaken/appearance: blue lips, mottled, gray-white
20M3 Respiratory Distress (one required):
  • Noisy breathing • Rapid, labored breathing
  • Sitting/leaning forward or standing to breathe
  • Speaks in short sentences • Pale and diaphoretic
20M4 Seizures: • multiple > 3 per hour
  • extended > 5 min.
20M5 Medication overdose, confirmed ingestion < 30 min
20M6 Confirmed ingestion of caustic substance w/difficulty swallowing
20M7 Life threatening congenital defects/anomalies
20M8 Illness/infection w/rapid onset (< 10 hours) w/
  • dramatic decrease in LOC • Listless, limp or quiet
  • drooling w/difficulty swallowing

BLS Red Response
20R1 Breathing difficulty
20R2 Seizures (any one):
  • First time seizure • w/history • w/fever
20R3 Medication overdose:
  • Unconfirmed • > 30 min since ingestion
20R4 Ingestion of caustic substances:
  • Unconfirmed • No difficulty swallowing
20R5 Congenital Health conditions/anomalies with:
  • Not feeling well • Non-specific symptoms
  • RP request for evaluation

BLS Yellow Response
20Y1
20Y2

TRP

20 Pediatrics
Background Information

Assault/Trauma

Statistically this is very seldom a paramedic response; however, it is important to get good information about weapons and injuries to identify those cases of penetrating injury (GSW or stabbing) above the hands or feet. MEDIC responses may also be needed in the patient with significant head injury with a decreased level of consciousness (e.g., comatose). Swelling of brain tissue due to bruising of the brain (contusion) and edema (swelling) of consciousness are indicators of brain injury. Uncontrolled bleeding is bleeding that cannot be controlled with direct pressure with a clean cloth or sanitary napkin.

Noncritical symptoms of head injuries include:

- Decreasing level of consciousness
- Difficulty of associated injuries
- Breathing difficulty - may be due to edema
- Combative patient - often due to a forced decrease in consciousness
- Loss of consciousness

Critical symptoms associated with head injuries include:

- Swelling of brain tissue due to bruising of the brain (contusion)
- Edema (swelling) of consciousness
- Decreasing level of consciousness
- Uncontrolled bleeding

If no severe to critical bleeding without success:

- Head injuries associated with decreased level of consciousness

Intervention:

A brief loss of consciousness is very seldom a paramedic response; however, it is important to get good information about weapons and injuries to identify those cases of penetrating injury (GSW or stabbing) above the hands or feet. MEDIC responses may also be needed in the patient with significant head injury with a decreased level of consciousness (e.g., comatose). Swelling of brain tissue due to bruising of the brain (contusion) and edema (swelling) of consciousness are indicators of brain injury. Uncontrolled bleeding is bleeding that cannot be controlled with direct pressure with a clean cloth or sanitary napkin.

Noncritical symptoms of head injuries include:

- Decreasing level of consciousness
- Difficulty of associated injuries
- Breathing difficulty - may be due to edema
- Combative patient - often due to a forced decrease in consciousness
- Loss of consciousness

Critical symptoms associated with head injuries include:

- Swelling of brain tissue due to bruising of the brain (contusion)
- Edema (swelling) of consciousness
- Decreasing level of consciousness
- Uncontrolled bleeding

If no severe to critical bleeding without success:

- Head injuries associated with decreased level of consciousness

Intervention:
**Pre-arrival Instructions**

- Do not remove/touch impaled object.
- Do not touch weapons or disturb scene.
- Preserve evidence.
- If unconscious, go directly to Unconscious/Breathing Normally - Airway Control (Trauma) instructions, Section IV.
- Have patient lie down and remain calm.
- If bleeding, use clean cloth and apply pressure directly over it. **DO NOT REMOVE.** Apply additional cloths on top, if needed.
- Patient should not change clothing, bathe or shower.
- Keep patient warm.
- Gather patient meds, if possible.

**BLS Red Response**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21M1</td>
<td>Unconscious or not breathing</td>
</tr>
<tr>
<td>21M2</td>
<td>Secondary to head injury:</td>
</tr>
<tr>
<td></td>
<td>• Decreased LOC • Disoriented or combative • Seizure</td>
</tr>
<tr>
<td>21M3</td>
<td>GSW or stabbing, crushing or penetrating injury, above hands or feet</td>
</tr>
<tr>
<td>21M4</td>
<td>Uncontrolled bleeding</td>
</tr>
<tr>
<td>21M5</td>
<td>Respiratory Distress (one required):</td>
</tr>
<tr>
<td></td>
<td>• Sitting/leaning forward or standing to breathe</td>
</tr>
<tr>
<td></td>
<td>• Speaks in short sentences • Noisy breathing</td>
</tr>
<tr>
<td></td>
<td>• Pale and diaphoretic • Rapid, labored breathing</td>
</tr>
</tbody>
</table>

**BLS Yellow Response**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21R1</td>
<td>GSW, stabbing, crushing or penetrating injury to hands or feet</td>
</tr>
<tr>
<td>21R2</td>
<td>Unknown injuries</td>
</tr>
<tr>
<td>21R3</td>
<td>Minor injuries with weapons</td>
</tr>
<tr>
<td>21R4</td>
<td>Multiple extremity fracture</td>
</tr>
<tr>
<td></td>
<td>• Single femur fracture • Hip fracture and/or dislocation</td>
</tr>
<tr>
<td>21R5</td>
<td>Single syncope, secondary to trauma</td>
</tr>
<tr>
<td>21R6</td>
<td>No verifiable info available from RP</td>
</tr>
<tr>
<td>21R7</td>
<td>Breathing difficulty</td>
</tr>
</tbody>
</table>

**TRP**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21T1</td>
<td>Minor injuries without weapons</td>
</tr>
<tr>
<td>21T2</td>
<td>Concerned without apparent injuries</td>
</tr>
<tr>
<td>21T3</td>
<td>Pain associated with recent medical surgical procedure</td>
</tr>
<tr>
<td>21T4</td>
<td>Isolated fracture/dislocation: • Extremity</td>
</tr>
<tr>
<td>21T5</td>
<td>Minor lacerations w/controlled bleeding</td>
</tr>
</tbody>
</table>

**Vital Points**

- **Medic:**
  - Ask to speak directly to the patient, if possible!
  - Is the suspect still in the area? **If yes,** get description
  - Is the scene secure?
  - Describe what happened.
  - Is the patient able to speak in full sentences?
  - Is the patient short of breath?
  - Can the patient respond to you and follow simple commands?
  - Can the patient answer your questions?
  - Is the patient combative (wanting to fight you)?
  - Is the patient seizing?
  - What was the patient assaulted with?
  - Where on their body were they injured?
  - Is the patient bleeding? **If yes:** How much? How long?
  - Can it be controlled with pressure?
  - Has the patient had a recent head injury? **If yes:** How long ago?

**Assault/Trauma**

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

**Short Report:**

- Has law enforcement been notified?
Background Information

Burns may be thermal, chemical, electrical, or solar.

Smoke Inhalation

Severe smoke inhalation often associated with significant carbon monoxide exposure and can cause collapse of the lungs or other acute respiratory distress. However, 25% of deaths are related to carbon monoxide exposure. Prolonged exposure can cause significant brain damage.

Critical burn injuries:

- Burns to the airway are very dangerous because of swallowing and secondary airway obstruction. Severity of burns is classified by the Rule of Nines:

  Critical burn injuries:

  - Third degree (denuded skin or exposed bone, tendons, or muscle)
  - Second degree (progressive denudement with edema and deep reddening)
  - First degree (erythema or blisters)

  Burns to the airway are very dangerous because of swallowing.

  Respiratory tract burns:

  - Airway (nose, mouth, larynx, trachea) or lungs

  Electrical burns:

  - Danger to tissues that is not seen along the path of the current through the body. Normal household current carries little danger, but 220 volts or greater can cause significant tissue damage and cardiac electrical dysfunction.

  Smoke inhalation, often associated with significant carbon monoxide exposure, should be suspected in the unconscious patient or decreased LOC patient.

  Burns - Thermal/Electrical/Chemical

  Burns to the airway are very dangerous because of swallowing and secondary airway obstruction. Severity of burns is classified by the Rule of Nines:

  - First degree (erythema or blisters)
  - Second degree (progressive denudement with edema and deep reddening)
  - Third degree (denuded skin or exposed bone, tendons, or muscle)

  Critical burn injuries:

  - Burns to the airway are very dangerous because of swallowing.

  Burns may be thermal, chemical, electrical, or solar.
### Vital Points

- **Ask to speak directly to the patient, if possible!**
- **Medic:**
  - Where is the patient burned?
  - Describe the extent of the burns?
  - Is the patient able to speak in full sentences?
  - Is the patient short of breath?
  - Is the patient having difficulty swallowing?
  - Where is the patient burned? If head or face burn:
    - Is the patient coughing?
    - Are the patient's nose hairs burned?
    - Is the patient burned around their mouth or nose?
    - If male, is the mustache burned?
  - How was the patient electrocuted?

### Pre-arrival Instructions

**For all types of burns:**
- If patient is unconscious, go directly to Unconscious/Breathing Normally - Airway Control (Trauma) Instructions, Section IV.
- If patient is unconscious and not breathing normally, go directly to Cardiac/Respiratory Arrest Instructions, Section IV.

**Electrical:** (Electrocution, Lightning Strike):
- Turn power off, if safe.

**Thermal:** (Heat, Smoke Inhalation, Hot Substances):
- Remove patient from heat source.
- If burning agent is still on skin (tar, hot oil, plastics), flush burned area in cool clean water (notice).
- For all other thermal burns, leave burn area exposed.

**Chemical:**
- Have patient remove contaminated clothing, if possible.
- Continuously flush chemicals from burns to eyes, remove contacts.
- If chemical is powder, brush off, no water.
- Get information on chemical (Acid/Alkali) (MSDS Sheet if available).

### Burns - Thermal/Electrical/Chemical

<table>
<thead>
<tr>
<th>Burns - Thermal/Electrical/Chemical</th>
<th>BLS Red Response</th>
<th>BLS Yellow Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>22T1 Spilled hot liquids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22T2 Battery explosion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22T3 Household electric shock, w/o Medic criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22T4 Burns over body surface: Adult &lt; 20% Child &lt; 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22T5 Chemical burns to eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22T6 No verifiable info available from RP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22T7 Breathing difficulty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22T8 Burns to hands, feet or genitals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BLS Red:**
- If household electrocution, what was the source?
- Are they still in contact with the electrical source?
- Are there any other injuries?

**BLS Yellow:**
- Small burn from match, cigarette
- Freezer burns
- Severe sunburn

**TRP**
- Pepper Spray or Taser
- Household electrical shock, no symptoms

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**Dispatch Criteria**

<table>
<thead>
<tr>
<th>Medic Response</th>
<th>Pre-arrival Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>22M1 Unconscious or not breathing</td>
<td>For all types of burns:</td>
</tr>
<tr>
<td>22M2</td>
<td></td>
</tr>
<tr>
<td>22M3 Respiratory Distress (one required):</td>
<td>If patient is unconscious, go directly to Unconscious/Breathing Normally - Airway Control (Trauma) Instructions, Section IV.</td>
</tr>
<tr>
<td>22M4 Burns to airway, nose, mouth, neck: (one required)</td>
<td>If patient is unconscious and not breathing normally, go directly to Cardiac/Respiratory Arrest Instructions, Section IV.</td>
</tr>
<tr>
<td>22M5 Hoarseness • Difficulty talking • Difficulty swallowing</td>
<td>Electrical: (Electrocution, Lightning Strike):</td>
</tr>
<tr>
<td>22M6 Burns over body surface: 20% or more adults and 10% or more children</td>
<td>Turn power off, if safe.</td>
</tr>
<tr>
<td>22M7 Electrical burns from power lines or panel boxes</td>
<td>Thermal: (Heat, Smoke Inhalation, Hot Substances):</td>
</tr>
<tr>
<td>22M8</td>
<td>Remove patient from heat source.</td>
</tr>
</tbody>
</table>

---

**Short Report**

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding
Background Information

It is very important to remember that there are often head or neck injuries present in water related accidents and near drowning victims. Also accidents involving scuba divers are often associated with air embolism or the "bends" which are nitrogen "bubbles" in the tissues. Patients that have been in cold water such as Puget Sound often have severe hypothermia and require additional support that a warm water victim does not require.

Noncritical incident: Confirmed submersion of the patient may be significant since many of these patients will develop lung difficulties after (up to 24 hours) they are pulled out of the water and are assumed to be okay.

Critical incident: Any respiratory difficulty will only get worse in the water. Additional advice that can be given to on scene FRs is to tell for all cases of the "bends" to develop.
Medic Response

**23M1** Unconscious or not breathing
- Sitting/leaning forward or standing to breathe
- Speaks in short sentences
- Noisy breathing
- Pale and diaphoretic
- Rapid, labored breathing

**23M3**
Scuba diving accident

**23M2** Respiratory Distress (one required):
- Is the patient able to speak in full sentences?
- Is the patient short of breath?
- Is this a scuba diving accident?

BLS Red Response

**23R1** Near drowning, patient conscious

**23R2** Patient coughing

**23R3** Other injuries: neck/back

**23R4** No verifiable info available from RP

**23R5** Breathing difficulty

**23R6** Patient confirmed submerged > 1 min. w/out Medic criteria

BLS Yellow Response

**23Y1** Minor water-related injury, patient not submerged:
- Isolated fractures/dislocation of arm/leg
- Major lacerations w/controlled bleeding

TRP

**23T1** Minor water-related injury, patient not submerged:
- Minor lacerations w/controlled bleeding
- Isolated fracture/dislocation of toe/finger

Vital Points

**Ask to speak directly to the patient, if possible!**

**Medic:**
- Is the patient able to speak in full sentences?
- Is the patient short of breath?
- Is this a scuba diving accident?

BLS Red:
- How long was the patient under water?
- Has the patient been removed from the water?
- What was the patient doing before the incident?

Drowning/Near Drowning/Diving or Water-related Injury

**Pre-arrival Instructions**
- If unconscious/not breathing normally, go directly to Cardiac Arrest Instruction, Section IV.
- Do not enter the water
- Toss them a flotation jacket/object, if available.
- If unconscious, go directly to Unconscious/Breathing Normally - Airway Control (Trauma) instructions, Section IV.
- Keep patient warm.
- Do not move patient around.

**Short Report:**
- Is the patient on land or in a boat?

**23  Drowning/Water Injury**
Much of EMS work in the trauma field is based on mechanism of injury, and this category depends significantly on the mechanism of injury to assess dispatch priorities.

Critical priorities:
- Falls associated with significant medical problems such as chest pain, dizziness, headache or diabetes may be heralding a life-threatening illness that should have evaluation.
- Industrial accidents with crushing or penetrating injury above the hands and feet have the potential for significant blood loss or vital organ impairment.
- Amputations above the level of the fingers or toes should have MEDIC evaluation for significant blood loss.
- Spinal injuries should have paramedic evaluation for neurogenic shock.
- Uncontrolled bleeding is bleeding that cannot be controlled by direct pressure with a clean cloth or sanitary napkin. Paramedics should not be dispatched until the RP has attempted to control bleeding without success.

Head Injuries:
- The best indicator of severity of injury in the head injured patient is the level of consciousness. A patient with a decreasing level of consciousness indicates there is ongoing injury to the brain. This may be a collection of blood around the brain, which is commonly a subdural or epidural hematoma. A patient with a decreasing level of consciousness is often combative or may show signs of decreased level of consciousness such as swelling of brain tissue due to bruising of the brain (contusion).

Noncritical symptoms of head injuries include:
- A brief loss of consciousness (< five minutes) followed by an awake, alert state (this is very common and does not indicate a critical level of injury).
- Amnesia for the event causing the injury.

Critical symptoms of head injuries include:
- Decreasing level of consciousness.
- Combative patient with frontal hematoma in the brain.
- Breathing difficulty - may be due to airway obstruction.
- Seizure following a head injury.

Spinal Injuries should have paramedic evaluation for neurogenic shock.

Critical Problems:
- Uncontrollable bleeding that cannot be controlled by direct pressure with a clean cloth or sanitary napkin.
- Decreasing level of consciousness.
- Breathing difficulty - may be due to airway obstruction.
- Seizures following a head injury.

Who of EMS work in the trauma field is based on mechanism of injury or within the trauma team (prehospital or hospital) that may be determining where the patient should be transported and, if necessary, the location of the neurosurgical service. The mechanism of injury is important in determining where the patient should be transported and, if necessary, the location of the neurosurgical service.
### Dispatch Criteria

**Medic Response**
- 24M1 Unconscious or not breathing
- 24M2 Decreased LOC, disoriented
- 24M3 Respiratory Distress (one required):
  - Sitting/leaning forward or standing to breathe
  - Fast breathing
  - Pale and diaphoretic
- 24M4 Trauma with signs of shock (three required):
  - Diaphoresis
  - Syncope, near syncope when sitting/standing
  - Pale, clammy skin
- 24M5
- 24M6
- 24M7 Amputation/entrapment above finger/toes
- 24M8 Patient paralyzed
- 24M9 Uncontrolled bleeding
- 24M0

**BLS Red Response**
- 24R1 Single syncope
- 24R2 Falls associated with or preceded by:
  - Pain/discomfort in chest
  - Dizziness
  - Headache
  - Diabetic
- 24R3 Amputation/entrapment of fingers/toes
- 24R4 Minor head/neck/shoulder injury
- 24R5 Patient trapped, without obvious injury
- 24R6
- 24R7 Multiple extremity fracture
  - Single femur fracture
  - Hip fracture and/or dislocation
- 24R8 No verifiable info available from RP
- 24R9 Breathing difficulty

**BLS Yellow Response**
- 24Y1 Major lacerations/controlled bleeding
- 24Y2 Patient assist
- 24Y3 Isolated extremity fracture, dislocation
- 24Y4 Hip pain

**TRP**
- 24T1 Minor lacerations (controlled bleeding), bumps or bruises
- 24T2 Involved in accident, no complaints
- 24T3 Neck/back/shoulder pain
- 24T4 Fracture/dislocation of finger or toe

### Vital Points

- **Medic:**
  - Ask to speak directly to the patient, if possible!
  - Is the patient able to speak in full sentences?
  - Is the patient short of breath?
  - Can the patient respond to you and follow simple commands?
  - Can the patient answer your questions?
  - How far did the patient fall?
  - What did the patient land on?
  - What part of the body has been amputated?
  - Do you have the amputated parts?
  - Is the patient able to move their fingers and toes?
  - Is the patient bleeding?
  - If yes, from where?

**BLS Red:**
- Are there any obvious injuries?
- Did the patient complain of any pain or illness just prior to the fall?
- If accident, what part of the body has been injured?

### Pre-arrival Instructions

- If unconscious, go directly to Unconscious/Breathing Normally - Airway Control (Trauma) instructions, Section IV.
- If machinery, turn it off. (Try to locate maintenance).
- Do not move patient (if no hazards).
- Do not allow patient to move.
- Cover patient w/ blanket and keep calm.
- Nothing by mouth.
- If bleeding, use clean cloth and apply pressure directly over it. DO NOT REMOVE apply additional cloths on top, if needed.
- Locate any amputated parts or skin and place in clean plastic bag, not on ice.
- Gather patient meds, if possible.

### Short Report

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding
Motor Vehicle Accident (MVA)

Much of EMS work in the trauma field is based on mechanism of injury, and this category depends significantly on the mechanism of injury to assess dispatch priorities.

Critical priorities:

- Confirmed or unknown injuries with the following mechanisms:
  - Vehicle (car/motorcycle) vs. immovable object
  - Car vs. pedestrian
  - Car vs. motorcycle or bicycle
  - Victim ejected from vehicle
  - MCI criteria

Other critical criteria include patients with:

- Head injury with decreased level of consciousness
- Chest pain precipitating accident
- Unconscious/not breathing

Noncritical criteria for MVA include:

- Rollover accidents (which have a low incidence of life-threatening injury)
- Patients who are walking about at scene
- Police call for injury evaluation
- Subjects who are awake and alert at scene
- Noise of MVA

Head Injuries

- The best indicator of severity of injury in the head injured patient is the level of consciousness. A patient with a decreasing level of consciousness indicates there is ongoing injury to the brain. This is often from a collection of blood that may be developing around the brain (subdural or epidural hematoma) or within the brain tissue (intracerebral hematoma). Swelling of brain tissue due to bruising of the brain (contusion) may also cause a deteriorating level of consciousness.

- Mechanism of injury is important in all trauma assessment. Head injuries are very commonly associated with cervical spine injuries and patients with head injuries should not be moved unless absolute life-threatening injury or consciousness is lacking. Head injuries are very commonly associated with cervical fractures and dislocations.

- Critical symptoms associated with head injuries include:
  - Decreasing level of consciousness
  - Combative patient - often due to a frontal hematoma
  - Breathing difficulty - may be due to airway difficulty or associated injuries
  - Seizures

- Noncritical symptoms include:
  - A brief loss of consciousness (5 minutes)
  - Amnesia (loss of memory)
**Dispatch Criteria**

**Medic Response**
- **25M1** Unconscious or not breathing
- **25M2** Decreased LOC, disoriented
- **25M3** Respiratory Distress (one required):
  - Sitting/leaning forward or standing to breathe
  - Speaks in short sentences
  - Noisy breathing
  - Pale and diaphoretic
  - Rapid, labored breathing
- **25M4** High rate of speed with no one moving or getting out of vehicles with any one of the following mechanisms:
  - Veh vs. immovable object
  - Veh vs. pedestrian
  - Veh vs. veh (head-on/t-bone)
- **25M5** MCI Criteria
- **25M6** Trauma with signs of shock (three required):
  - Diaphoresis
  - Pale, clammy skin
  - Nausea
  - Syncope/near syncope when sitting/standing
- **25M7** Patients ejected

**BLS Red Response**
- **25R1** Injury accident:
  - Low speed
  - Victims walking around
  - Unknown extent of injuries
- **25R2** Roll-over
- **25R3** No verifiable info available from RP
- **25R4** Victim trapped

**BLS Yellow Response**
- **25Y1**
- **25Y2** Request for evaluation via personnel on location:
  - Police
  - Fire Dept.

**TRP**

**Vital Points**
- **Ask to speak directly to the patient, if possible!**

**Medic:**
- Did the caller stop or drive by?
- How many patients are injured?
- Are the patients able to respond to you and follow simple commands?
- Are the patients short of breath?
- Are all of the patients free of the vehicle?
- Is anyone trapped in the vehicle due to injuries?
- Was anyone thrown from the vehicle?
- How fast was the vehicle traveling?

**BLS Red:**
- Can the patient describe where their pain is located?

**BLS Yellow:**
- Are there any hazards present?
  - Fire?
  - Water?
  - Wires down?

**Motor Vehicle Accident (MVA)**

**Pre-arrival Instructions**
- Do not move (if no hazards).
- If bleeding, use clean cloth and apply pressure directly over it. **DO NOT REMOVE!** apply additional cloths on top, if needed.
- If unconscious, go directly to Unconscious/Breathing Normally - Airway Control (Trauma) instructions, Section IV.
- Gather patient meds, if possible.

**Short Report**
- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

**25 Motor Vehicle (MVA)**
AUTOMATED EXTERNAL DEFIBRILLATOR INSTRUCTIONS

• Has anyone there been trained to use the defibrillator?

• Get the person flat on his/her back on the floor.

• Bring the defibrillator next to the person’s ear. Make sure it is not touching the person.

• Kneel next to the person.

• Bare his/her chest.

• Open the defibrillator case. (Look for a zipper, snaps on the side or a black button on the lid.)

If help is needed, use the following instructions:

( Remind RP that help has been dispatched.)

• Pull out and open the foil pouch containing the electrode pads.

• Peel the backing off the pads.

• Place the pads on the person’s chest following the pictures. Look to see that one pad is on the person’s upper right chest, below the collarbone, and the other pad is on the person’s left side, below the armpit.

• Check that the cords to the pads are plugged into the defibrillator. If not, do so now. (If the defibrillator is HeartStream, tell rescuer to plug in the cord at the flashing yellow light.)

• Push the green button to turn on the machine.

• “Analyzing” means the defibrillator is deciding whether to shock.

• Push the shock button if told to do so. (DO NOT touch the person. No one should be touching the cords or the person during analysis.)

The defibrillator will give one of two messages: “Shock advised” or “No shock advised.”

YES

NO

SHOCK ADVISED: (No shock will be given at this time)

• Is she/he conscious & breathing normally?

YES

SHOCK ADVISED:

• Begin CPR. I will help you.

NO

SHOCK ADVISED: (No shock will be given at this time)

• Place the pads on the person’s chest following the pictures. Look to see that one pad is on the person’s upper right chest, below the collarbone, and the other pad is on the person’s left side, below the armpit.

• Check that the cords to the pads are plugged into the defibrillator. If not, do so now. (If the defibrillator is HeartStream, tell rescuer to plug in the cord at the flashing yellow light.)

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The defibrillator will give one of two messages: “Shock advised” or “No shock advised.”

YES

NO

SHOCK ADVISED:

• Has anyone there been trained to use the defibrillator?

• Get the person flat on his/her back on the floor.

• Bring the defibrillator next to the person’s ear. Make sure it is not touching the person.

• Kneel next to the person.

• Bare his/her chest.

• Open the defibrillator case. (Look for a zipper, snaps on the side or a black button on the lid.)

If help is needed, use the following instructions:

( Remind RP that help has been dispatched.)

• Pull out and open the foil pouch containing the electrode pads.

• Peel the backing off the pads.

• Place the pads on the person’s chest following the pictures. Look to see that one pad is on the person’s upper right chest, below the collarbone, and the other pad is on the person’s left side, below the armpit.

• Check that the cords to the pads are plugged into the defibrillator. If not, do so now. (If the defibrillator is HeartStream, tell rescuer to plug in the cord at the flashing yellow light.)

• Push the green button to turn on the machine.

• “Analyzing” means the defibrillator is deciding whether to shock.

• Push the shock button if told to do so. (DO NOT touch the person. No one should be touching the cords or the person during analysis.)

The defibrillator will give one of two messages: “Shock advised” or “No shock advised.”

YES

NO

SHOCK ADVISED: (No shock will be given at this time)
CARDIAC/RESPIRATORY ARREST/Adults

1. Does anyone there know CPR? (Trained bystanders may still need instructions. Ask!) 

2. Get the phone NEXT to the person, if you can. 

3. Listen carefully. I’ll tell you what to do. 
   - Get him/her FLAT on his/her back on the floor. 
   - BARE the chest. 
   - KNEEL by his/her side. 
   - PINCH the nose. 
   - With your OTHER hand, LIFT the CHIN so the head BENDS BACK. 
   - COMPLETELY COVER his/her mouth with your mouth. 
   - GIVE 2 BREATHS of AIR into his/her LUNGS — just like your blowing up a big balloon. 

REMEMBER: 
   - FLAT on his/her BACK. 
   - BARE the CHEST. 
   - PINCH THE NOSE. 
   - With your OTHER hand, LIFT the CHIN so the head BENDS BACK. GIVE 2 BREATHS. 
   - THEN, COME BACK TO THE PHONE! If I’m not here, stay on the line. 

4. Is he/she MOVING or BREATHING NORMALLY? 
   (If yes): Roll the person on his/her side and check for breathing until help takes over. 
   (If NO): Listen carefully. I’ll tell you what to do next. 
   - Put the HEEL of your HAND on the CENTER of his/her CHEST, right BETWEEN the NIPPLES. 
   - Put your OTHER HAND ON TOP of THAT hand. 
   - PUSH DOWN FIRMLY, ONLY on the HEELS of your hands, 1-1/2 to 2 inches. 
   - Do it 15 times, just like you’re PUMPING his/her chest. 
   - Count OUTLOUD so I can hear you, like this 1-2-3... 
   - MAKE SURE the HEEL of your hand is on the CENTER of his/her chest, RIGHT BETWEEN the NIPPLES. 
   - Pump 15 times. 
   - Then, PINCH the NOSE and LIFT the CHIN so the head BENDS BACK. 
   - 2 MORE breaths and PUMP the CHEST 15 times. 
   - KEEP DOING IT: PUMP the CHEST 15 times. Then 2 BREATHS. 
   - KEEP DOING IT UNTIL HELP CAN TAKE OVER. 
   - I’ll stay on the line. 

NOTE: IF CALLER REPORTS VOMITING, INSTRUCT CALLER TO: 
   - Turn his/her head to one side. 
   - Sweep it all out with your fingers before you start mouth-to-mouth
CARDIAC RESPIRATORY ARREST/Children 1-8 Years

1. Does anyone there know CHILD CPR?  (Trained bystanders may still need instructions. Ask!)

2. Listen carefully. I'll tell you what to do.
   - Move the child to a HARD surface (table or floor) near the phone.
   - BARE the chest.
   - PINCH the NOSE.
   - With your OTHER hand, LIFT the CHIN and TILT the head back.
   - Completely COVER his/her mouth with your mouth and give 2 breaths.

3. Is the child BREATHING NORMALLY?
   (If yes): Roll the child on his/her side and check for breathing until help takes over.
   (If NO): Do it again. REMEMBER, PINCH the nose. With your OTHER hand, LIFT the CHIN so the head BENDS BACK
   - Completely COVER his/her mouth with your mouth and give 2 breaths.
   - Then come BACK to the phone. If I’m not here, stay on the line.

4. Did the chest rise?  (If no: Go to CHOKING/Children).

5. Is he/she breathing normally?
   (If yes): Roll the child on his/her side and check for breathing until help takes over.
   (If NO): Listen carefully. I’ll tell you what to do next.
   - Put the HEEL of ONLY ONE HAND on the CENTER of the chest, right BETWEEN the NIPPLES.
   - PUSH down 1 to 1-1/2 inches.
   - Do this 5 times QUICKLY.
   - Count OUTLOUD so I can hear you, like this 1-2-3-4-5.
   - Then PINCH the NOSE, LIFT the CHIN, and tilt the head back.
   - Give one breath.
   - Keep doing it until help can take over. I’ll stay on the line.

NOTE: IF CALLER REPORTS VOMITING, INSTRUCT CALLER TO:
   - Turn his/her head to one side.
   - Sweep it all out with your fingers before you start mouth-to-mouth.
CARDIAC/RESPIRATORY ARREST/ Infants 0-12 Months

1. Does anyone there know INFANT CPR? (Trained bystanders may still need instructions. Ask!)

2. Bring the baby to the phone.

3. Listen carefully. I’ll tell you what to do.
   - Lay the baby FLAT on his/her BACK on a table.
   - BARE the baby’s CHEST.
   - LIFT the CHIN slightly. MAKE SURE THE NECK REMAINS LEVEL.
   - TIGHTLY COVER the baby’s MOUTH AND NOSE with your mouth.
   - GIVE 2 BREATHS of air into his/her lungs.
   - Then come back to the phone. If I’m not here, stay on the line.

4. Is the baby breathing normally?
   - (If yes): Roll the baby on his/her side and check for breathing until help takes over.
   - (If NO): Do it again. REMEMBER — LIFT THE CHIN slightly, MAKING SURE THE NECK REMAINS LEVEL.
     - COMPLETELY COVER the baby’s MOUTH AND NOSE with your mouth and
     - GENTLY GIVE 2 BREATHS into his/her LUNGS.
     - Then come back to the phone.

5. Did the chest rise? (If no: Go to CHOKING/Infants.)

6. Is the baby breathing normally?
   - (If yes): Roll the baby on his/her side and check for breathing until help takes over.
   - (If NO): Listen carefully. I’ll tell you what to do next.
     - Put your FIRST AND MIDDLE fingertips on the CENTER of the chest, right BETWEEN the NIPPLES.
     - PUSH down SLIGHTLY — 1/2 to 1 inch. Do it 5 times RAPIDLY.
     - Count OUTLOUD so I can hear you, like this 1-2-3-4-5.
     - Go do that. Then come back to the phone.

7. Listen carefully.
   - NEXT, LIFT the CHIN slightly, MAKING SURE THE NECK REMAINS LEVEL, and give one quick breath of air.
   - Then, put your FIRST AND MIDDLE FINGERS on the CENTER OF THE CHEST, right BETWEEN the NIPPLES.
   - PUSH down SLIGHTLY — 1/2 to 1 inch. Do it 5 times RAPIDLY
   - Count OUTLOUD 1-2-3-4-5, blow; 1-2-3-4-5, blow.
   - KEEP DOING THIS. REMEMBER, one breath, then 5 quick compressions.
   - Keep doing it until help takes over. I’ll stay on the line.

NOTE: IF CALLER REPORTS VOMITING, INSTRUCT CALLER TO:
   - Turn his/her head to the side.
   - Sweep it out with your fingers before you start mouth-to-mouth.
CPR FOR THE PREGNANT WOMAN

1. Does anyone there know CPR? (Trained bystanders may still need instructions. Ask!)
2. Get the phone NEXT to her, if you can.
3. Listen carefully. I'll tell you what to do.
   - Get her FLAT on her BACK on the floor.
   - Get a pillow or folded blanket, and WEDGE it under the RIGHT SMALL of the BACK.
   - BARE the chest. KNEEL by her side.
   - PINCH the nose.
   - With your OTHER hand, LIFT the CHIN so the head BENDS BACK.
   - COMPLETELY COVER her mouth with your mouth.
   - GIVE 2 breaths of air into his/her lungs — just like you’re blowing up a big balloon.

REMEMBER:
- FLAT on her BACK.
- WEDGE the pillow under the RIGHT SMALL of the BACK.
- BARE the chest.
- PINCH the nose.
- With your OTHER hand, LIFT the CHIN so the head BENDS BACK.
- GIVE 2 breaths.
- THEN, COME BACK TO THE PHONE! If I’m not here, stay on the line.

4. Is she MOVING or BREATHING NORMALLY?
   (If yes): Roll her on her left side and check for breathing until help takes over.
   (If NO): Listen carefully, I’ll tell you what to do next.
   - Put the HEEL of your HAND on the CENTER of her CHEST, right BETWEEN the NIPPLES.
   - Put your OTHER HAND ON TOP of THAT hand.
   - PUSH DOWN FIRML Y, ONLY on the HEELS of your hands, 1-1/2 to 2 inches.
   - Do it 15 times, just like you’re PUMPING her chest.
   - Count OUTLOUD so that I can hear you, like this 1-2-3...
   - MAKE SURE the HEEL of your hand is on the CENTER of her chest, RIGHT BETWEEN the NIPPLES. Pump 15 times.
   - Then, PINCH the NOSE and LIFT the CHIN so the head BENDS BACK.
   - 2 MORE breaths and PUMP the CHEST 15 times.
   - KEEP DOING IT: PUMP the CHEST 15 times. Then 2 BREATHS.
   - KEEP DOING IT UNTIL HELP CAN TAKE OVER. I’ll stay on the line.

NOTE: When the woman is flat on her back, the position of the pregnant uterus can put pressure on the iliac vessels, the inferior vena cava and the abdominal aorta. To lesson this pressure, the person who is going to do CPR can wedge a pillow or a folded blanket, under the right small of the back, thus moving the uterus to the left side of the abdomen and alleviating pressure on areas where blood flow is vital.

BACKGROUND INFORMATION: Causes of cardiac arrest during pregnancy can be any of the following:
- Pulmonary embolism (blockage of the pulmonary artery by blood clot);
- Hypovolemia (diminished blood supply due to internal hemorrhaging);
- Amniotic fluid embolism;
- Congenital and acquired cardiac disease;
- Trauma.

REVISED 05/04
CARDIAC/RESPIRATORY ARREST/NECK BREATHERS
(Tracheostomy/Laryngectomy Patients)

Some patients have a tracheostomy, a surgical opening in their necks. This may be a result of a laryngectomy (removal of part of the upper airway) or other problem. This opening is called a “stoma” and the person breathes through it rather than through their mouth and nose. The stoma connects the airway (trachea) to the skin of the neck. This may appear as a small 1/2 inch slit or hole in the neck or as a metal or plastic flange plate with a “breathing hole.” All patients with a stoma must be ventilated through this opening, NOT through the nose and mouth. In most patients, the mouth and nose are no longer connected to the lungs (laryngectomy), but in some there is still a partial connection through which air could escape (partial laryngectomy). In such cases the mouth and nose must be blocked whenever the patient is being ventilated through the stoma, or the air blown in will go out through the mouth and nose instead of into the lungs.

1. Does anyone there know CPR? (Trained bystanders may still need instructions. Ask!)
2. Get the phone NEXT to the person, if you can.
3. Listen carefully. I'll tell you what to do.
   - Get him/her FLAT on his/her BACK on the floor.
   - BARE the CHEST and NECK. KNEEL by his/her side.
   - TILT the head back slightly. DO NOT let it turn to the side.
   - COMPLETELY SEAL the MOUTH by covering it with your hand and PINCH the NOSE shut.
   - COMPLETELY COVER the stoma with your MOUTH and GIVE 2 BREATHS of air into his/her LUNGS — just like you’re blowing up a big balloon.

REMEMBER:
- FLAT on his/her BACK.
- BARE the CHEST and NECK. KNEEL by his/her side.
- TILT the head back slightly. DO NOT let it turn to the side.
- COMPLETELY SEAL the MOUTH and PINCH the NOSE shut.
- COMPLETELY COVER the stoma with your MOUTH. GIVE 2 BREATHS.
- THEN, COME BACK TO THE PHONE! If I’m not here, STAY ON THE LINE!

4. Is he/she MOVING or BREATHING NORMALLY?
   (If yes): Check for breathing until help takes over.
   (If NO): Listen carefully. I’ll tell you what to do next.
   - Put the HEEL of your HAND on the CENTER of his/her CHEST, right BETWEEN the NIPPLES.
   - Put your OTHER HAND ON TOP of THAT hand.
   - PUSH DOWN FIRMLY, ONLY on the HEELS of your hands, 1-1/2 to 2 inches.
   - Do it 15 times, just like you’re PUMPING his/her chest.
   - Count OUTLOUD so I can hear you, like this 1-2-3...
   - MAKE SURE the HEEL of your hand is on the CENTER of his/her chest, RIGHT BETWEEN the NIPPLES. Pump 15 times.
   - COMPLETELY SEAL the MOUTH and PINCH the NOSE shut.
   - COMPLETELY COVER the stoma with your MOUTH. GIVE 2 BREATHS.
   - KEEP DOING IT: PUMP the CHEST 15 times. Then 2 BREATHS.
   - KEEP DOING IT UNTIL HELP CAN TAKE OVER.
   - I’ll stay on the line.

NOTES:
- Remember to have them completely seal the mouth and pinch nose when performing ventilations through the stoma.
- If the caller reports that the neck opening is encrusted with mucous, instruct the caller to clean the opening with a clean cloth or handkerchief.
CHOKING INSTRUCTIONS FOR PREGNANT WOMEN & OBESE PERSONS

If event is NOT WITNESSED and the person is UNCONSCIOUS:

Go to CARDIAC/RESPIRATORY ARREST/Adults or CPR for Pregnant Women

If WITNESSED and person is CONSCIOUS: Follow Step 1 below.

1. Is the person able to TALK or COUGH:
   (If yes): STOP.
   (If NO):
   Listen carefully. I’ll tell you what to do next:
   • Stand BEHIND the person.
   • With your arms directly under the person’s armpits, ENCIRCLE his/her CHEST.
   • Place the thumb side of one fist on the MIDDLE of the his/her BREASTBONE.
   • GRAB that fist with your other hand and THRUST INWARD until the object is expelled.
   • If the person becomes unconscious, come back to the phone.

If WITNESSED and person is UNCONSCIOUS or becomes UNCONSCIOUS:

Follow steps 1-2 below.

1. Is the person MOVING or BREATHING?
   (If yes): ROLL the person on his/her SIDE and CHECK FOR BREATHING:
   • Complete the process until the object is expelled.
   • Roll the person on his/her SIDE and CHECK FOR BREATHING again.
   • If you see something, try to SWEEP it out. DON’T push the object backwards.
   • Is the person MOVING or BREATHING?
     (If NO): Listen carefully. I’ll tell you what to do next:
     • Place the person FLAT on his/her back on the floor.
     • Get a pillow or a blanket and WEDGE it under the RIGHT SMALL of the BACK.
     • Kneel by his/her side.
     • PINCH the NOSE. With your other hand, LIFT the CHIN so the head bends back.
     • Completely COVER his/her mouth with yours.
     • GIVE 2 BREATHS of air into his/her lungs, just like you're blowing up a big balloon. Watch to see if the chest rises. If the chest does not rise, repeat the above process. If the chest still does not rise:
     • BARE the chest.
     • Place the HEEL of your hand on the center of his/her chest, right between the nipples.
     • Press into the chest with FIRM, downward thrusts five (5) times.
     • Next:
     • Lift the CHIN so the HEAD bends back. OPEN the MOUTH.
     • If you see something, try to SWEEP it out. DON’T push the object backwards.
     • Is the person MOVING or BREATHING?
       (If NO): Listen carefully. I’ll tell you what to do next:
       • Roll the person on his/her SIDE and CHECK FOR BREATHING until the object is expelled.

If the person becomes unconscious, come back to the phone.
CHOKING/Adult

If event is NOT WITNESSED and person is UNCONSCIOUS: Go to CARDIAC/RESPIRATORY ARREST/Adults.

If person is CONSCIOUS:

1. Is the person able to TALK or COUGH?
   (If yes, STOP.)
   (If NO): Listen carefully. I’ll tell you what to do next.
   • Stand BEHIND the person. Wrap your arms AROUND the waist.
   • Make a fist with ONE hand and place it against the STOMACH, in the MIDDLE slightly ABOVE the navel.
   • GRASP your fist with the other hand.
   • PRESS into the stomach with QUICK, UPWARD thrusts. Repeat thrusts until the item is expelled.
   • If he/she becomes unconscious, come back to the phone.

If person is UNCONSCIOUS or becomes UNCONSCIOUS:

1. Is the person MOVING or BREATHING?
   (If yes): ROLL the person on his/her SIDE and CHECK FOR BREATHING until help takes over.
   (If NO): Listen carefully. I’ll tell you what to do next.
   • PINCH the NOSE. With your other hand, LIFT the CHIN so the head bends back.
   • Completely COVER his/her mouth with yours.
   • GIVE 2 BREATHS of air, just like you’re blowing up a big balloon. Watch to see if the chest rises.

2. Did the CHEST RISE?
   (If yes, ask): Is the person MOVING or BREATHING?
   (If yes): ROLL the person on his/her SIDE and CHECK FOR BREATHING until help takes over.
   (If no, the chest DID NOT RISE): Listen carefully. I’ll tell you what to do next.
   • Get him/her FLAT on his/her back on the floor.
   • BARE the chest and STRADDLE the THIGHS.
   • Place the HEEL of your hand against the stomach, in the MIDDLE, slightly above the NAVEL.
   • Place your other hand directly on TOP of the first hand. PRESS into the stomach with QUICK, UPWARD thrusts. Do 5 of these thrusts, then come back to the phone.
   • If I’m not here, stay on the line.

3. Is the person MOVING or BREATHING?
   (If yes): ROLL the person on his/her SIDE and CHECK FOR BREATHING until help takes over.
   (If NO): Listen carefully. I’ll tell you what to do next.
   • Lift the CHIN so the HEAD bends back. OPEN the mouth.
   • IF you SEE something, turn the head to the side and try to SWEEP it out. DON’T push the object backwards.
   • If nothing is visible, Repeat Step 1-3 until:
     • the item is expelled, or
     • the person begins breathing, or
     • help arrives. Keep trying!
**CHOKING/Child (Children 1-8 Years)**

If **event is NOT WITNESSED** and child is **UNCONSCIOUS**: Go to **CARDIAC/RESPIRATORY ARREST/Child**.

If child is **CONSCIOUS**:  

1. **Is the child able to TALK or COUGH?**  
   - **(If yes, STOP.)**
   - **(If NO):** Listen carefully. I’ll tell you what to do next.
   - **Stand BEHIND the child. Wrap your arms AROUND the waist.**
   - **Make a fist with ONE hand and place it against the STOMACH, in the MIDDLE slightly ABOVE the navel.**
   - **GRASP** your fist with the other hand.
   - **PRESS** into the stomach with QUICK, UPWARD thrusts. Repeat thrusts until the item is expelled.
   - **If child becomes unconscious, come back to the phone.**

**IF THE CHILD IS, OR BECOMES, UNCONSCIOUS:**

1. **Is the child MOVING or BREATHING?**
   - **(If yes):** ROLL the child on his/her SIDE and CHECK FOR BREATHING until help takes over.
   - **(If NO):** Listen carefully. I’ll tell you what to do next.
   - **PINCH the NOSE.** With your other hand, LIFT the CHIN so the head bends back.
   - **Completely COVER** his/her mouth with yours.
   - **GIVE 2 BREATHS** of air. Watch to see if the chest rises.

2. **Did the CHEST RISE?**
   - **(If yes, ask):** Is the child MOVING or BREATHING?
   - **(If yes):** ROLL the child on his/her SIDE and CHECK FOR BREATHING until help takes over.
   - **(If NO):** Listen carefully, I’ll tell you what to do next:
   - **Lift the CHIN** so the head BENDS BACK. OPEN the mouth.
   - **IF you SEE** something, turn the head to the side and try to SWEEP it out. **DON’T** push the object backwards.
   - **If nothing visible, Repeat steps 1-4 until the item is expelled, the child begins breathing, or help arrives. Keep trying!**

3. **If the chest does not rise, continue:**
   - Get him/her FLAT on his/her back on the floor. **BARE** the chest and STRADDLE the THIGHS.
   - Place the HEEL of your hand against the stomach, in the MIDDLE, slightly above the NAVAL.
   - Place your other hand directly on TOP of the first hand. PRESS into the stomach with QUICK, UPWARD thrusts. Do 5 of these thrusts, then come back to the phone.
   - **If I’m not here, stay on the line.**

4. **Is the child MOVING or BREATHING?**
   - **(If yes):** ROLL the child on his/her SIDE and CHECK FOR BREATHING until help takes over.
   - **(If NO):** Listen carefully, I’ll tell you what to do next:
   - **Lift the CHIN** so the head BENDS BACK. OPEN the mouth.
   - **IF you SEE** something, turn the head to the side and try to SWEEP it out. **DON’T** push the object backwards.
   - **If nothing visible, Repeat steps 1-4 until the item is expelled, the child begins breathing, or help arrives. Keep trying!**
CHOKING/Infant - CONSCIOUS (Infants 0-12 Months)

If the event is UNWITNESSED and infant is UNCONSCIOUS, go to CARDIAC/RESPIRATORY ARREST/infants.

If the infant is CONSCIOUS:

1. There might be something blocking the baby's airway. Bring the baby to the phone.

2. Is the baby able to CRY or COUGH? (If yes, stop.)
   (If NO)
   Listen carefully. I'll tell you what to do next:
   · Bare the baby's chest.
   · Pick up the baby, and turn the baby FACE DOWN so he/she lies along your forearm.
   · Support the baby's JAW in your HAND with your arm resting on your thigh for support.
   · Tilt the baby, with the head down slightly. Use the heel of your other HAND to strike the BACK 5 times, right between the SHOULDER BLADES. Do that and come back to the phone.

3. Listen carefully.
   · Lay the baby FLAT on his/her back on a table or a hard surface.
   · Put your FIRST and MIDDLE FINGERS directly BETWEEN the NIPPLES.
   · Push down ½ to 1 inch. Push down 5 times RAPIDLY.
   · Count OUTLOUD so I can hear you, like this: 1-2-3-4-5.
   · Do that and come back to the phone.

4. Is the baby breathing?
   (If NO): Repeat steps 2 – 4 until the item is expelled or the baby becomes unconscious.
   (If YES): Roll the baby on his/her SIDE and CHECK FOR BREATHING until help takes over.

IF THE BABY BECOMES UNCONSCIOUS, GO TO INSTRUCTIONS ON THE FOLLOWING PAGE.
CHOKING/Infant - UNCONSCIOUS (Infants 0-12 Months)

1. Is the baby MOVING or BREATHING?
   (If yes): ROLL the baby on his/her SIDE and CHECK FOR BREATHING until help takes over.
   (If NO): Listen carefully. I'll tell you what to do next.
   • Get the baby FLAT on his/her back.
   • TIGHTLY cover the baby's MOUTH AND NOSE with your mouth. Make sure the baby's neck remains level.
   • GIVE 2 BREATHS of air into the baby, watching to see if the chest rises.
   • Do that and COME BACK to the phone.

2. Did the CHEST RISE?
   (If yes): Is the baby MOVING or BREATHING?
       (If yes): ROLL the baby on his/her SIDE and CHECK FOR BREATHING until help takes over.
       (If NO): Go to CARDIAC/RESPIRATORY ARREST/Infants.
   (If NO, the chest DID NOT rise):
   • Make sure the baby's neck remains level, then TIGHTLY cover the baby's MOUTH AND NOSE with your mouth.
   • GIVE 2 BREATHS of air into the baby, watching to see if the chest rises.
   • Do that and COME BACK to the phone.

3. If the chest DID NOT RISE while giving the breaths:
   • Turn the baby FACE DOWN so he/she lies along your forearm.
   • SUPPORT the baby's JAW in your HAND with your arm resting on your thigh for support.
   • TILT the baby, with the head down slightly.
   • Use the heel of your other HAND to strike the BACK 5 times, right between the SHOULDER BLADES. Do that and come back to the phone.

4. Next:
   • Lay the baby FLAT on his/her back on a table or hard surface.
   • Put your FIRST and MIDDLE FINGERS directly BETWEEN the NIPPLES.
   • Push down ½ to 1 inch. Push down 5 times RAPIDLY.
   • Count OUTLOUD so I can hear you, like this 1-2-3-4-5.
   • Do that and come back to the phone.

5. Is the baby MOVING or BREATHING?
   (If yes): ROLL the baby on his/her SIDE and CHECK FOR BREATHING until help takes over.
   (If NO):
   • Make sure the baby’s mouth is clear.
   • IF you see something, turn the head to the side and try to SWEEP it out.
   • DON'T push the object backwards.
   • LIFT the CHIN slightly, MAKING SURE THE NECK REMAINS LEVEL.

6. If nothing visible, Repeat steps 1 – 5 until the item is expelled, the baby begins breathing or help takes over.
   KEEP TRYING!
UNCONSCIOUS PATIENT/BREATHING NORMALLY - AIRWAY CONTROL

BREATHING NORMALLY (Non-trauma)

1. Listen carefully. I’ll tell you what to do.
   • Roll the patient on his/her side.
   • Check for normal breathing until help takes over:
     • Watch for the chest to rise and fall.
     • Put your cheek next to the nose and mouth to listen and feel for air movement.

2. If the patient stops breathing normally or vomits, call back. I have advised the dispatcher to send help.

   Vomiting/Unconscious Person
   • Listen carefully. I’ll tell you what to do.
     • Turn his/her head to the side.
     • Sweep it all out of the mouth with your fingers.

     • Is the person breathing normally?
       (If yes): Continue watching the person. If the person stops breathing normally, CALL BACK.
       (If NO): Go to CHOKING, determine appropriate age group.

BREATHING NORMALLY (Trauma)

1. Listen carefully. I’ll tell you what to do.
   • Do not move the patient (especially head and neck), unless imminent danger to life.
   • Check for normal breathing until help takes over:
     • Watch for the chest to rise and fall.
     • Put your cheek next to the nose and mouth to listen and feel for air movement.

2. If the patient stops breathing normally or vomits, call back. I have advised the dispatcher to send help.

   Vomiting/Unconscious Person
   • Listen carefully. I’ll tell you what to do.
     • Do not turn his/her head.
     • Sweep it all out of the mouth with your fingers.

     • Is the person breathing normally?
       (If yes): Continue watching the person. If the person stops breathing normally, CALL BACK.
       (If NO): Go to CHOKING, determine appropriate age group.

NOTE: Vomiting in an unconscious person is very serious. If possible, try to stay on the line until emergency personnel arrive at the scene.
1. Have you had a baby before?

2. How many minutes between your contractions? Contractions with less than 2 minutes between the end of one and the start of the next, especially if the woman feels a strong desire to push, indicates birth may be imminent.

3. If there are more than 2 minutes between contractions:
   - Lie in a comfortable position on your back or side.
   - Relax your body. Tell the mother to relax, and relax the soles of the feet.
   - Keep the perineal area elevated with slightly above the level of the bed.
   - Wrap the baby in towels or blankets and place it between your legs on the floor.
   - When the baby is delivered, gently try to clean the mouth and nose with a clean, dry cloth.
   - Try to stay calm and do not startle. This is normal.

4. If the baby begins to deliver (crowning and pushing):
   - The baby’s head should deliver first.
   - There will be water and blood with delivery. This is normal.
   - When the baby is delivered, gently try to clean the mouth and nose with a clean, dry cloth.
   - BEND your KNEES.
   - Lie down on your BACK on the towels and relax. Breathing DEEPLY through your MOUTH.
   - Remove your underwear.
   - If possible, get some clean towels or sheets. Place some on the floor. Keep the rest handy for later.
   - Try to stay calm. Stay on the line with me or keep the phone nearby.
   - If possible, get some clean towels or sheets. Place some on the floor. Keep the rest handy for later.
   - If the baby does NOT start breathing on its own, rub its back or gently slap the soles of the feet. Try to stay calm. Stay on the line with me or keep the phone nearby.
   - If possible, stay on the line with me. Listen carefully. I'll tell you what to do.

5. If there are complications (leg, arm, buttocks or umbilical cord presenting):
   - REASSURE the mother. Tell the mother you have dispatched aid.
   - Ask her to remain on her back with her knees bent.
   - Ask her to relax and breathe through her nose.
   - Tell her NOT to push.
   - Tell her to RELAX and BREATHE through her MOUTH.
   - Help her remain dispersed.
   - Have you had a baby before? (For woman by herself)
CHILDBIRTH

1. Has she had a baby before?
2. How many minutes between her contractions/pains? Contractions with less than 2 minutes between the end of one and the start of the next (especially if the women feels a strong desire to push), indicate birth may be imminent.
3. If there are less than 2 minutes between contractions: Listen carefully. I’ll tell you what to do. Have her LIE in a comfortable position on the BACK or SIDE and have her take DEEP breaths. Help has been dispatched.
4. If contractions are less than 2 minutes between contractions and if there is a strong desire to push: Listen carefully, I’ll tell you what to do.
   • Get the phone NEXT to her, if you can.
   • Ask her to LIE on her BACK and relax; breathing DEEPLY through her MOUTH.
   • Ask her to remove underwear and BEND her KNEES.
   • Place clean towels UNDER her BUTTOCKS and have additional clean towels ready.
5. If she starts to deliver (water broken, bloody discharge, baby's head appears): Listen carefully. I’ll tell you what to do.
   • The baby’s head should deliver first. CRADLE it and the rest of the baby as it is delivered. DO NOT PUSH OR PULL.
   • There will be water and blood with delivery. THIS IS NORMAL.
   • When the baby is delivered, CLEAN out it’s MOUTH and NOSE with a CLEAN, DRY cloth.
   • Do NOT attempt to CUT or PULL the cord.
   • There will be water and blood with delivery. THIS IS NORMAL.
   • Wrap the baby in a blanket, a towel, or whatever is handy, and place it between mother’s legs on the floor.
   • Massage mother’s lower abdomen very gently.
   • If the baby does NOT start breathing on its own, rub its back or gently slap the soles of its feet. If the baby DOESN’T begin breathing IMMEDIATELY, come back to the phone.
   • If the baby does not begin breathing on its own: Go to CARDIAC/RESPIRATORY ARREST/Infants.
   • When the placenta (tissue at the other end of the umbilical cord) is delivered, WRAP IT. This delivery may take as long as 20 minutes.
   • Keep the placenta LEVEL with or SLIGHTLY ABOVE the baby.
   • If you need additional help or advice, CALL BACK (or come back to the phone). If possible, STAY ON THE LINE.
6. If there are complications (leg, arm, buttocks or umbilical cord presenting):
   • REASSURE the mother. Tell her you have dispatched aid.
   • Firmly massage the lower abdomen in a circular motion.
   • (To treat for shock): Keep the mother warm and elevate legs.
   • Place a sanitary napkin over the vaginal opening.
   • (If a foot or arm presents, delivery is not possible in the field.) Support the baby with your hands, allowing the buttocks and trunk to deliver spontaneously. Support the legs and trunk of the infant. NEVER attempt to pull baby from vagina by legs or trunk.
   • Raise the infant's body up until its face protrudes.
   • Did the baby deliver?
   • (If unsuccessful, provide an airway for the baby): Push the vaginal wall away from baby's face.
   • Keep doing that until help arrives.
   • If the head does not deliver within 3 minutes of trying the above: Maintain the airway. Don’t pull or touch the extremity. Place the mother on either side with legs and buttocks elevated.
7. Postpartum Hemorrhage (external bleeding from the vagina, persistent abdominal rigidity or tenderness and signs of shock.)
   • Firmly massage the lower abdomen in a circular motion.
   • (To treat for shock): Keep the mother warm and elevate legs.
   • Place a sanitary napkin over the vaginal opening.
8. Breech presentation
   • If a foot or arm presents, delivery is not possible in the field.
   • Support the baby with your hands, allowing the buttocks and trunk to deliver spontaneously.
   • Support the legs and trunk of the infant. NEVER attempt to pull baby from vagina by legs or trunk.
   • Raise the infant's body up until its face protrudes.
   • Did the baby deliver?
   • (If unsuccessful, provide an airway for the baby): Push the vaginal wall away from baby's face.
   • Keep doing that until help arrives.
   • If the head does not deliver within 3 minutes of trying the above: Maintain the airway. Don’t pull or touch the extremity. Place the mother on either side with legs and buttocks elevated.
9. Prolapsed Umbilical Cord
   Place the mother on her knees with her head resting on the floor and her buttocks in the air. DO not permit her to lie flat.