

## August 2009 SOP Review

Respiratory SOP's and 1<sup>st</sup> Half of Medical (through  
snakebite/envenomation)

### Objectives

Emphasize revisions to Respiratory SOP's through 1<sup>st</sup> half  
of Medical SOP's

Re-examine all of the respiratory SOP's and 1st half of  
medical to refresh all!

### Drug of the Month: Zofran

### EKG of the Month: Widened QRS complex

### Skills of the Month

BLS: Assessment of the stroke patient

ALS: Nasal Atomizer

**Illinois Region 8 Emergency Medical Services  
Central DuPage, Edward, Good Samaritan, Loyola EMS Systems  
Standard Operating Procedures**

**ADULT AIRWAY OBSTRUCTION**

**BLS/ALS**

1. Determine responsiveness and ability to speak
2. Position patient to open airway:
  - If unconscious: use head tilt/chin lift
  - If possible C-spine injury: use modified jaw thrust
3. Assess breathlessness/degree of airway impairment
4. Monitor for:
  - Cardiac dysrhythmias and/or arrest

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**CONSCIOUS**

**ABLE TO SPEAK:**

5. **Complete Initial Medical Care:**
  - Do not interfere with patient's own attempts to clear airway

**CANNOT SPEAK:**

5. 5 abdominal thrusts with patient standing or sitting  
5 chest thrusts if patient in 2<sup>nd</sup> – 3<sup>rd</sup> trimester of pregnancy or morbidly obese
  - Repeat if no response
6. **If successful: complete Initial Medical Care** and transport
7. **Still obstructed:**  
While enroute to the hospital, continue any of the above steps you are reasonably able to perform

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**UNCONSCIOUS**

**Note:** Any time the efforts to clear the airway are successful, complete **Initial Medical Care** and transport

8. Attempt to ventilate. If obstructed:
  - Attempt to clear away using the finger sweep method unless contraindicated
  - Consider suction

If still obstructed and unconscious, repeat above steps until airway is clear

**ALS**

9. Visualize airway with laryngoscope and attempt to clear using forceps and/or suction
10. **Still obstructed:** Attempt forced ventilation
11. **Still obstructed: INTUBATE** and attempt to push foreign body into right mainstem bronchus, then pull tube back and ventilate left lung
12. **Still obstructed: Perform cricothyroidotomy; HIGH FiO<sub>2</sub> VENTILATION** and transport

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**ADULT DRUG ASSISTED INTUBATION - ETOMIDATE**

**ALS**

This SOP is to be used for patients > 15 years of age. If ≤ 15 years of age, see Drug Assisted Intubation – Versed.

1. **Initial Medical Care** - the following are situations which may require the use of this SOP to facilitate intubation:
  - Glasgow coma score < 8
  - Imminent respiratory arrest
  - Imminent tracheal/laryngeal closure due to severe edema secondary to trauma or anaphylaxis
  - Flail chest and/or open chest wounds with cyanosis and a respiratory rate < 10 or > 30

**ALWAYS HAVE CRICOTHYROIDOTOMY EQUIPMENT AVAILABLE**
2. Prepare patient and equipment for procedure
  - Position patient in sniffing position unless contraindicated (i.e. C-spine injury)
  - Have suction with Yankauer or other rigid tip ready
  - Prepare all intubation and cricothyroidotomy equipment per System-specific procedure
  - **HIGH FiO<sub>2</sub> VENTILATION prior to and in-between steps of this procedure as able**

**Head Injured Patients**

3. **BENZOCAINE spray** to posterior pharynx (1-2 second spray x 2, 30 seconds apart)
4. **ETOMIDATE 0.6 mg/kg rapid IV/IO**
5. Perform Sellick's maneuver until tube passed and cuff inflated
6. Attempt oral or oral in-line intubation via System-specific procedure
7. After passing of tube, verify placement:
  - Positive bilateral breath sounds
  - Negative epigastric sounds
  - ETCO<sub>2</sub> detector / EDD per System-specific procedure
8. Secure ETT and reassess placement

**POST INTUBATION SEDATION**

9. **VERSED 2 mg increments IV/IO** up to 10 mg total as necessary

**THERE IS NO REPEAT ETOMIDATE DOSE FOR HEAD INJURED PATIENTS**

**Non-Traumatic Patients**

3. **BENZOCAINE spray** to posterior pharynx (1-2 second spray x 2, 30 seconds apart)
4. **ETOMIDATE 0.3 mg/kg rapid IV/IO**
5. Perform Sellick's maneuver until tube passed and cuff inflated
6. Attempt oral or oral in-line intubation via System-specific procedure
7. If proper muscle tone relaxation has not been achieved to allow for intubation (i.e. intact bite), after 1-2 minutes may **repeat ETOMIDATE 0.3 mg/kg rapid IV/IO**
8. After passing of tube, verify placement:
  - Positive bilateral breath sounds
  - Negative epigastric sounds
  - ETCO<sub>2</sub> detector / EDD per System-specific procedure
9. Secure ETT and reassess placement

**POST INTUBATION SEDATION**

10. **VERSED 2 mg increments IV/IO** up to 10 mg total as necessary

**If unsuccessful, continue HIGH FiO<sub>2</sub> VENTILATION, contact Medical Control, and be prepared for cricothyroidotomy per System-specific procedure**

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**ADULT DRUG ASSISTED INTUBATION - VERSED**

**ALS**

1. **Initial Medical Care** - the following are situations which may require the use of this SOP to facilitate intubation:
  - Glasgow coma score < 8
  - Imminent respiratory arrest
  - Imminent tracheal/laryngeal closure due to severe edema secondary to trauma or anaphylaxis
  - Flail chest and/or open chest wounds with cyanosis and a respiratory rate < 10 or > 30

**ALWAYS HAVE CRICOTHYROIDOTOMY EQUIPMENT AVAILABLE**

2. Prepare patient and equipment for procedure
  - Position patient in sniffing position unless contraindicated (i.e. C-spine injury)
  - Have suction with Yankauer or other rigid tip ready
  - Prepare all intubation and cricothyroidotomy equipment per System-specific procedure
  - **HIGH FiO<sub>2</sub> VENTILATION** prior to and in-between steps of this procedure as able

**ADULTS**

3. **VERSED 5 mg IV/IO/IN, may repeat VERSED 2 mg increments IV/IO up to 10 mg until sedation achieved. If unable to obtain vascular access, may repeat VERSED 5 mg IN x 1 until sedation achieved.**
4. Perform Sellick's maneuver until tube passed and cuff inflated
5. **BENZOCAINE spray** to posterior pharynx (1-2 second spray x 2, 30 seconds apart)
6. Attempt oral or oral in-line intubation via System-specific procedure
7. After passing of tube, verify placement:
  - Positive bilateral breath sounds
  - Negative epigastric sounds
  - ETCO<sub>2</sub> detector / EDD per System-specific procedure
8. Secure ETT and reassess placement

**POST INTUBATION SEDATION**

9. **VERSED 2mg increments IV/IO up to 10 mg as necessary**

**If unsuccessful, continue HIGH FiO<sub>2</sub> VENTILATION, contact Medical Control, and be prepared for cricothyroidotomy per System-specific procedure**

**NOTE:**

- The maximum total dose of VERSED is 20 mg, as follows:
  - ◆ Up to 10 mg pre-intubation
  - ◆ Up to 10 mg post successful intubation for sedation

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**USE OF AUTOMATIC TRANSPORT VENTILATORS (ATV)  
(OPTIONAL EQUIPMENT)**

**ALS**

**Indications for ATV use:** intubated adult apneic/non-traumatic full arrest patients that require ventilator support. Medical control must approve use on pediatric patients.

Contraindications for ATV use:

- patients with suspected pneumothorax or tension pneumothorax
- traumatic arrest patients

Required equipment:

- approved ATV connected to oxygen source
- intubation equipment including BVM and ETCO<sub>2</sub> detector

**ATV procedure**

1. Establish definitive airway
2. Assemble components of ATV and ensure proper working order
3. Determine proper tidal volume and respiratory rate using the following guidelines:
  - a. tidal volume: 10 mL/kg -- when in doubt, round down
  - b. rate: 8-10 per minute (may increase to 12-20 per minute if perfusing rhythm returns)
4. Remove BVM and connect ATV to endotracheal tube. Continually assessed for proper functioning of the ATV and return of spontaneous respirations.
5. If the patient should begin spontaneous respirations, stop the use of the ATV and assist ventilations within BVM.

**Special Information:**

- Specific ATVs are to receive system approval prior to their use
- Providers using this equipment must follow the manufacturer's guidelines regarding the use, maintenance, cleaning and regular testing of the device.
- During patient care, personnel shall chart the initial settings, and any subsequent changes on the patient care report.
- Specific ATV training programs are to be submitted and to receive approval from the respective EMS system. Initial annual training shall be documented.
- This is an optional piece of equipment. The purchase and maintenance is the responsibility of the provider. All ATVs shall be lightweight and rugged in design, capable of operating under common environmental conditions and extremes of temperature.

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**ADULT ACUTE ASTHMA  
COPD WITH WHEEZING  
REACTIVE (LOWER) AIRWAY DISEASE**

**BLS**

1. **Initial Medical Care**
2. If patient has prescribed inhaler, obtain time of last dosage. If appropriate, assist patient with inhaler
3. Reassess patient's respiratory status and begin transport
4. At discretion of Medical Control, additional doses of inhaler may be given
5. **ALBUTEROL 2.5 mg (3 mL) via nebulizer** per System-specific Procedure
6. Consider possibility of CHF / pulmonary edema in wheezing patient, if patient has a history of CHF, and/or pulmonary edema. If so, treat per Pulmonary Edema SOP

**ALS**

1. **Initial Medical Care.**
2. **ALBUTEROL 2.5 mg (3 mL) or XOPENEX 1.25 mg (3 mL)** via nebulizer
3. Partial response: **repeat ALBUTEROL or XOPENEX** immediately
4. If **no response to ALBUTEROL or XOPENEX** or **patient in severe respiratory distress** AND age  $\leq 50$  and patient has no history of cardiac disease:
  - **EPINEPHRINE 1:1000 0.3 mg IM**
    - ◆ If  $> 50$  and/or cardiac disease history, contact Medical Control
5. If imminent respiratory arrest, **INTUBATE** and use in-line **ALBUTEROL 2.5 mg (3 mL) or XOPENEX 1.25 mg (3 mL)**

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**ADULT PARTIAL (UPPER) AIRWAY OBSTRUCTION / EPIGLOTTITIS**

**ALS/BLS**

1. **Initial Medical Care**
2. Prepare intubation / cricothyroidotomy / suction equipment

**ALS**

**STABLE**

- No cyanosis, effective air change.
3. **NS 6 mL nebulizer**
  4. If wheezing: **ALBUTEROL 2.5 mg (3 mL)** or **XOPENEX 1.25 mg (3 mL)** via nebulizer. Nebulizer supplied with oxygen at 6 LPM. **Do not delay transport waiting for a response.**

**UNSTABLE**

- Cyanosis, marked stridor or respiratory distress, evidence of inadequate air exchange, bradycardic, altered mental status, retractions, ineffective air exchange, actual or impending respiratory arrest

**Breathing:**

3. **EPINEPHRINE 1:1000 3 mg (3 mL)** via nebulizer

**Nonbreathing:**

3. **HIGH FiO<sub>2</sub> VENTILATION**
  - Attempt **OROTRACHEAL INTUBATION x once** if unable to ventilate
  - If intubation unsuccessful, perform **CRICOTHYROIDOTOMY**

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**ADULT ALLERGIC REACTION / ANAPHYLAXIS**

**BLS/ALS**

1. **Initial Medical Care**
2. Apply ice/cold pack to site
3. BLS: at the direction of Medical Control, administer one dose **EPINEPHRINE** auto-injector (Epi-pen)

**ALS**

**Allergic reaction with systemic signs**, i.e. wheezing, diffuse hives, or prior history of systemic reaction, without signs of hypoperfusion

4. **BENADRYL 50 mg IM or slow IV**
5. **EPINEPHRINE 1:1000 0.3 mg IM**. May repeat x 1 after 15 minutes if minimal response

If wheezing, consider **ALBUTEROL 2.5 mg (3 mL )** or **XOPENEX 1.25 mg (3 mL )** per acute asthma SOP

**ALS**

**Anaphylaxis: multisystem reaction with signs of hypoperfusion**; altered mental status or severe respiratory distress/wheezing/hypoxia

4. If signs of hypoperfusion, **IV/IO fluid challenges in 200 mL increments**
5. **EPINEPHRINE 1:10,000 0.5 mg slow IV/IO or 1 mg ET**  
or **EPINEPHRINE 1:1000 0.5 mg injected sublingual or IM**
  - May repeat q 3 minutes
6. **BENADRYL 50 mg slow IV/IO**. If no IV, give IM.
7. Consider **ALBUTEROL** or **XOPENEX** per Acute Asthma SOP
8. Consider **DOPAMINE** per Cardiogenic Shock SOP for refractory hypotension

**Note**

- **Epinephrine** may be given IM if IV/IO access delayed

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**ADULT DIABETIC / GLUCOSE EMERGENCIES**

**BLS/ALS**

**1. Initial Medical Care**

- Obtain medication history and last oral intake
- Vomiting and seizure precautions

2. Obtain and record blood glucose level, if available

3. If blood sugar < 60 and patient is alert with intact gag reflex, consider the administration of **ORAL GLUCOSE**

**ALS**

**Blood glucose < 60 or signs and symptoms of Insulin Shock / Hypoglycemia**

4. **DEXTROSE 50% 25 g (50 mL) IV.** If partial or no improvement, repeat **DEXTROSE 50% 25 g (50 mL) IV**

5. If unable to start IV, **GLUCAGON 1 mg IM**

**Blood sugar > 180 with signs and symptoms of Hyperglycemia / Ketoacidosis**

4. **IV FLUID CHALLENGE** in consecutive 200 mL increments, unless contraindicated

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**ADULT SYNCOPE / NEAR SYNCOPE  
Non-traumatic loss of consciousness**

**BLS/ALS**

1. **Initial Medical Care**
2. Obtain and record blood glucose level (BLS - if available.) If < 60, treat per Diabetic / Glucose Emergencies SOP

**BLS**

3. Expedient transport. Contact Medical Control enroute

**ALS.**

**STABLE: alert, normotensive**

- Special considerations:
  - Monitor ECG continually enroute
  - Consider 12-lead ECG
  - Document changes in GCS
- 3. Anticipate underlying etiologies and treat according to appropriate SOP:
  - Metabolic                                      Diabetes or Poisoning/Overdose SOP
  - Cardiac    Appropriate Dysrhythmia or Cardiogenic Shock SOP
  - Hypovolemic                                    Fluid Resuscitation
  - CNS Disorder                                    See appropriate Medical or Trauma SOP
  - Vasovagal                                        Initial Medical Care

**UNSTABLE: altered mental status and/or signs of hypoperfusion**

If lungs clear and hypoperfusing:

4. **IV FLUID CHALLENGES in 200 mL increments**

If indicated by decreasing sensorium and pinpoint pupils, depressed respirations, and possible history of narcotic / synthetic narcotic ingestion:

4. **NARCAN 2 mg IV. May repeat NARCAN q 5 minutes** PRN if transient response observed

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**ADULT SEIZURES / STATUS EPILEPTICUS  
Non-traumatic origin**

**BLS/ALS**

1. **Initial Medical Care**; special considerations:
  - Clear and protect airway. Vomiting/aspiration precautions.
  - Protect the patient from injury. Do not place anything in mouth if seizing.
  - Position patient on side unless contraindicated
2. Obtain and record blood glucose level, if available. If < 60 treat per Diabetic / Glucose Emergencies SOP.

**ALS**

If actively seizing:

**Adult**

3. **VERSED 2 mg slow IV increments q 2 minutes up to 10 mg.**
4. If unable to start IV:
  - **VERSED 10 mg in 2 mL** via Nasal Atomizer
  - Or
  - **VERSED IM**
    - ◆ < 70 kg = 5 mg IM
    - ◆ ≥ 70 kg = 10 mg IM

**Note: If suspected that seizure is secondary to narcotic overdose, see Toxicologic Emergencies SOP**

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**ADULT STROKE**

**BLS/ALS**

**1. Initial Medical Care.**

- Limit scene time
- C-spine control for unconscious patients with suspected trauma
- Obtain and record time of onset of symptoms

**2. Protect airway, suction as necessary**

**3. Maintain head and neck in neutral alignment. DO NOT flex neck. If SBP > 90 mmHg, elevate head of bed 15-30°**

**4. Monitor and record neurological status using GCS, and note any changes**

**5. Assess patient using the Cincinnati Stroke Scale:**

- Facial Droop (have patient show teeth or smile)
- Arm Drift (patient closes eyes and hold both arms out)
- Speech (have patient say "You can't teach an old dog new tricks")

**ALS**

- Consider 12-lead ECG

**6. INTUBATE if GCS ≤ 8**

**7. Establish IV, limit IV attempts to 2**

**8. If seizure activity, refer to Seizure SOP**

**9. Call Medical Control early and communicate time of last normal appearance per patient or witness**

**10. Transport to the closest appropriate facility for continuation of stroke care**

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**ADULT ACUTE ABDOMINAL PAIN**

**BLS/ALS**

**1. Initial Medical Care**

**STABLE:** alert, normotensive

**2. Consider pain management:**

- **MORPHINE SULFATE 2 mg IV increments** up to 10 mg total

**3. If patient experiencing nausea, consider **ZOFRAN ODT 4 mg tab placed sublingually** x 1 dose only**

**UNSTABLE:** altered mental status and signs of hypoperfusion

**4. Establish large bore IV enroute. Administer **IV FLUID bolus 200 mL**, repeat as necessary. Titrate infusion rate based on clinical presentation.**

**5. If suspected abdominal aortic aneurysm or ectopic pregnancy, early aggressive fluid resuscitation should be considered.**

**6. If signs and symptoms of shock present, establish second IV.**

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**ADULT TOXICOLOGIC EMERGENCIES**

**BLS/ALS**

**STABLE:** alert, normotensive

**1. Initial Medical Care**

- HazMat precautions

**ALS**

**UNSTABLE:** altered mental status, airway compromise, and/or hypoperfusion

**1. Initial Medical Care**

- HazMat precautions
- 2. GCS  $\leq$  8 and evidence of airway compromise, **INTUBATE**. The use of Alternative Airway is contraindicated in ingestion of caustic substance.
- 3. Unknown etiology with respiratory compromise:

**NARCAN 2 mg IV/IN.** May repeat q 5 minutes PRN

**NARCOTIC OVERDOSE**

For known narcotic overdose with GCS  $\leq$  8;

- Protect airway, **HIGH FiO<sub>2</sub> OXYGEN or VENTILATION**
- Consider **NARCAN 2 mg IV/IN** before intubation if airway is able to be controlled and ventilations are effective

**CYCLIC ANTIDEPRESSANT OVERDOSE**

Hypoperfusion associate with wide QRS complex (possible cyclic ingestion)

**4. IV WIDE OPEN**

**SODIUM BICARBONATE 8.4% 1 mEq/kg IV**

**BETA-BLOCKER / CALCIUM CHANNEL BLOCKER OVERDOSE**

Hypoperfusion associated with bradycardia (possible Beta Blocker or Calcium Channel Blocker ingestion)

- 4. GLUCAGON 1 mg slow IV.** May repeat x 1. If no response consider TCP.

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**ORGANOPHOSPHATE POISONING** - excessive body secretions

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<b>D</b> – Diarrhea	<b>OR</b>	Salivation (excessive production of saliva)
<b>U</b> – Urination		Lacrimation (excessive tearing)
<b>M</b> – Miosis		Urination (uncontrolled urine production)
<b>B</b> – Bronchorrhea / Bronchospasm		Defecation (uncontrolled bowel movement)
<b>B</b> – Bradycardia		Gastrointestinal distress (cramps)
<b>E</b> – Emesis		Emesis (excessive vomiting)
<b>L</b> – Lacrimation		Breathing Difficulty
<b>S</b> - Salivation		Arrhythmias
		Miosis (pinpoint pupils)

4. **ATROPINE 2 mg rapid IV/IO**  
Repeat **q 3** minutes until condition improves (no dose limit)

**CYANIDE POISONING**

4. For known cyanide poisoning; **AMYL NITRITE capsule broken and taped inside an NRB mask or BVM with high FiO<sub>2</sub>**. Begin transport while **replacing capsules q 1 minute x 12 capsules**.
- **INTUBATE only** if patient apneic after all 12 capsules used.
  - If hypotensive or pulseless, **IV WIDE OPEN**

**CARBON MONOXIDE POISONING**

- **HIGH FiO<sub>2</sub> OXYGEN or VENTILATION**
- Do not rely on pulse oximetry
- Keep patient as quiet as possible to minimize tissue oxygen demand

**SUSPECTED CLUB DRUG OVERDOSE**

4. Contact Medical Control for suspected use of club drugs

<b><u>Narcotics:</u></b>	Morphine, Demerol, Heroine, Methadone, Codeine, Fentanyl, Vicodin, Hydrocodone, Dilaudid, Darvon, Percocet, Lortab, OxyContin, Duragesic patch
<b><u>Cyclic Antidepressants:</u></b>	Elavil (amitriptyline), Norpramin (desipramine), Tofranil (imipramine), Pamelor (nortriptyline), Sinequan (doxepine)
<b><u>Benzodiazepines:</u></b>	Halcion, Ativan, Restoril, Versed, Valium, Xanax, Librium, Klonopin, Dalmane, Rohypnol, Ambien
<b><u>Beta Blockers:</u></b>	Inderal (propranolol), Corgard, Lopressor, atenolol, Tenormin, Timolol
<b><u>Calcium Channel Blockers:</u></b>	Cardizem (diltiazem), Procardia (nifedipine), Calan / Adalat / Isoptin (verapamil), Norvasc (amlodipine)
<b><u>Club Drugs:</u></b>	GHB (Liquid G, Liquid Ecstasy), ketamine (Special K, Vitamin K, Super K), MDMA (Ecstasy, XTC, ADAM, E), Foxy Methoxy, AMT, Coricidin (Triple-C)

Poison Center: 1-800-222-1222

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**SNAKEBITE / ENVENOMATION**

**BLS/ALS**

**Scene Size-up**

1. Assess scene and personal safety
2. Universal blood and body secretion precautions (BSI) on all patients

**1. Initial Medical Care**

- Secure and maintain patent airway
- **Oxygen at high FiO<sub>2</sub>**
- Check pulse and control hemorrhage as indicated
- Assess AVPU and monitor neurological status
- Apply sterile gauze dressing over wound
- Remove all jewelry and/or constrictive clothing

**2. Initial Medical Care; special considerations**

- Allow patient to lie flat and avoid as much movement as possible. Keep patient calm. Allow the bitten limb to rest at level of the patient's heart.
- Medical Control should be contacted immediately whenever snakebite is suspected. Notify Medical Control if anti-venom is available at the scene. Request that medical control contact toxicologist / Illinois Poison Center ASAP (1-800-222-1222)
- Notify Medical Control of type of snake. If safe to do so, obtain photo of snake for identification.
- If compression wrap has been applied by special services staff (i.e. animal control or zoological park), do not remove.
- DO NOT apply ice, heat, tourniquet or incise wound.

**ALS**

3. Observe for respiratory compromise. Provide intervention, if necessary, per appropriate SOP.
4. Evaluate cardiac rhythm. Treat dysrhythmias per appropriate SOP.
5. Establish two large bore IVs of normal saline in unaffected extremity.
6. Use direct pressure to control hemorrhage if present. Avoid elevation of extremities.
7. Reassess frequently for mental status changes.

**Note: If transport time > 15 minutes, consider contacting specialty transport. If anti-venom is available, bring to ED with patient.**