EMT Skill Sheet

Skill #10 - Patient Assessment – Medical
(Awake talking Patients without significate MOI)

Student Name: _____ Pass date - _____

Evaluator Name_____ Signature: _____
(Sign if Student Passes Skill)

Students must have pen, sharpie, light pen, stethoscope, blank paper on Clipboard, VS Post it notes & First Out equipment Date

Dispatched:	Patient Contact:	Transport:	End of Call:	

Information on this skill can be found in the Text Book and on the class D2L website		**Comments**
SCENE SIZE-UP – Starts prior to Patient contact but continues throughout the call		
Uses body substance isolation precautions of Gloves and Eye Protection **(Critical Fail!)**		
Scene Size-up Evaluation (Information from Dispatch or EMRs) – **Safety (Critical Fail!)**, Mechanism of Injury (MOI) – C-spine needed, Nature of Illness (NOI), Additional Resources, # of Patients		
PRIMARY ASSESSMENT (Primary Survey/Initial Assessment) - Done on Scene		
General Impression of the scene, patient & gathers information from EMRs or bystanders. Must observe: ✓ Unusual Environmental Factors (Hazards, Odors/Temperature, Lighting, Entrances/Exits, People) ✓ Patient's approximate Age, Sex, and Mental Status/ LOC (Level of Consciousness) ✓ Patient's Positioning, Level of Distress (Breathing/Pain), and any Gross Injuries seen ✓ Looking for Arterial Bleeding and ***≈If necessary*** - applying bleeding control as soon as possible		
Considers C-spine (Spinal Motion Restriction) for the Patient **(Critical Fail!)** – When in doubt – C-spine EMT should evaluate the scene for MOI (Mechanism of Injury). Does patient meet any of the following; • Significant MOI (MVC at high speed, Falls>20 feet) with Neck/Back Pain or Neurological deficit • Unresponsive/AMS (Altered Mental Status or Drugs/ETOH) patients with unknown history of event • Water related accidents, head/neck injuries, hangings If Yes to the above - Tell patient not to move and directs an EMT to hold manual stabilization (Skill #4)		
Identifies self by Name, Level of Medical training, Agency & gets Patient's consent (Expressed/Implied)		
Determines responsiveness of Patient by AVPU - May visualize for signs of Breathing at this time ✓ Awake - If patient is Alert must ask Person, Place, Time and Event orientation questions ✓ Responses to Verbal – check to see if patient can follow commands or answer questions ✓ Physical then Pain - check to see if patient can follow commands, open eyes or answer questions ✓ Unresponsive – **NO** response to Painful stimulus (Do no harm – neck/ear pinch, push bone above eye)		
≈If necessary - If patient is Unresponsive to Pain start with Circulation not Airway (2015 ECC BLS)		
Asks Patient – Name, Age and Chief Complaint • Determines patient's condition and considers calling for ALS if necessary • **If EMT partner is present ask them to get full set of Vital Signs after getting Patient consent**		
Continues to assess the need for C-spine – ✓ Ask patient/witnesses if they have had any trauma (falls, assaults, MVC, head injury) If Yes – ask patient if they have head/neck/back pain and/or weakness/numbness to their extremities? ➢ Hold manual stabilization on Trauma patients that have neck/back pain or neurological deficits		
Airway - Assesses and Fixes **(Critical Fail!)** ✓ Listen for noise – snoring, stridor, gurgling, wheeze ✓ Smell for odors – ETOH (alcohol), emesis, ketones, unusual odors (must be within 3 feet of Head) ✓ **Ask if patient if they are nauseated or had emesis if awake** Considers if Airway is Good (Adequate) or Bad (Inadequate) ➢ **Signs/Symptoms (s/s) that Airway is Patent/Adequate** – Patient is awake and maintaining their own airway, no abnormal noises heard (stridor, snoring, gurgling), Patient can speak clearly, No oral trauma or obstructions (blood, vomit, fluid, swelling) are noted ➢ **Signs/Symptoms that Airway is Inadequate** – Diminished level of responsiveness, Abnormal noises heard (stridor, snoring, gurgling), Drooling, Difficulty speaking clearly, actively vomiting If Airway is Inadequate or Patient with Altered Mental Status (AMS) - Open mouth and look for Obstruction – broken teeth, dentures, edema, emesis, blood (use light pen) ***≈If necessary*** – Fixes Airway (Skill #2) • Suctions patient as needed • Open and maintain airway with Head-Tilt Chin-Lift/Jaw-Thrust if patient is not maintaining Airway due to decreased mental status • Considers Airway Adjunct for all Patient's with AMS - OPA or NPA		

Breathing - Assesses and Fixes **(Critical Fail!)** – This may be done in Mental status assessment ✓ **Ask Patient if they are having any trouble Breathing** ✓ Looks for bilateral chest rise/listens for noisy breathing (Feels for chest rise in AMS patients) ➢ **Breathing is Adequate** – Equal rise and fall of chest bilaterally, Non-labored, Patient is Awake with good mental status, no abnormal noise heard, breathing is full, appears to be a good rate (12-20), Pink dry skin, patient can speak in full sentences ➢ **Breathing is Inadequate** – Labored breathing, Abnormal noises (stridor, wheezes, coughing, or noisy breathing), Bad rate (<12 or > 20), Shallow breathing, Patient is tripoding, using accessory muscles, Pale /cyanotic skin, unable to speak full sentences, (Nasal flaring, Grunting, Retractions, or Seesaw breathing - Kids) – patients with Decreased mental status should be carefully assessed • **If Breathing is labored - Describes level of Dyspnea as Mild, Moderate or Severe** (**get SpO2**)		
Considers Ventilation and Oxygen for the Patient – **(Critical Fail!)** (Skill #1) ***≈If patient has*** **- Adequate Breathing & No life threating Complaint &/or signs of Hypoxia/Shock** ✓ Oxygen therapy may not be required ***≈If patient has*** **- Adequate Breathing but life threating signs of Hypoxia or Shock** Directs an EMT to provide O2 therapy and place SpO2 on patient (**keep SpO2 greater or equal to 94%**) ✓ NC 1-6 LPM – Little Sick without Life Threating Complaints or only mild Respiratory distress ✓ NRM 15 LPM – Big Sick, Hypoxic, AMS, CO poisoning, Shock, or Respiratory distress (>Mild) ✓ Considers CPAP for moderate to severe Respiratory distress. Considers contraindications of CPAP ***≈If patient has*** **- Signs of Inadequate Breathing (Slow, Shallow, Unequal/Inadequate chest rise)** ✓ Directs 2 EMT/EMRs to provide positive pressure ventilation with BVM (Oxygen at 15 LPM)		
Circulation - Assesses and Fixes **(Critical Fail!)** ✓ Pulse **(Considers the Strength, Speed-fast/slow, and Regularity)** assess for up to 10 seconds ✓ Checks Skin signs (**Moisture/Color/Temperature**) and Cap Refill • Signs or symptoms of Shock must be treated in Primary Assessment (Skill #5)		
≈If necessary - Considers CPR and AED placement if there is no pulse in patient		
Deformities - Rapid Scan in all Patients (30-60 seconds) *(Trauma or AMS Patients use Skill #9)* ✓ Head – Visualize for deformities. Visualize ears, nose and mouth for edema, trauma, bleeding or ecchymosis, and facial symmetry (ask patient to smile as needed) ✓ Neck – Visualize for JVD, swelling, rash or bleeding ✓ Chest – Visualize equal rise & fall of chest and ask Patient to take deep breath and move (non-trauma) for pleuritic pain • *EMT may check Lung Sounds (Bases & Apexes) for Dyspneic or Chest Pain patients* ✓ Abdomen – Ask patient if they have abdominal pain. Expose if patient complains of abdominal Pain • *EMT may palpate 4 quadrants of abdominal if an assessment as needed* ✓ Pelvis – Visualize for incontinence (urine/feces) ✓ Extremities – (non-trauma) ask patient to move all extremities and check CMS* in all extremities ✓ Posterior – Visualize for abnormalities, rash or trauma and ask about neck/back pain ***≈If necessary*** **- Provides bleeding control** (Skill #5) **or occlusive dressing (Critical Fail!)** ➢ Some EMTs just do a quick visual scan without palpation on awake medical/trauma Patients ➢ Some EMTs expose and exam patient's chief complaint area in Primary Assessment * CMS – Circulation, Motor and Sensory Function (also called Neurovascular Function and PMS – Pulse/Motor/Sensory)		
Expose and Examine - To the appropriate level (Age, Mental status, Injury, Environment) ✓ Head and Chest should be exposed in Critical Patients (Head Coverings/Shirt)		
Consider and verbalizes to EMT partner(s) the following – Patient Priority (Life Threats) – 1. Appears – Stable (Little Sick); ➢ Mental Status & ABCDs normal and no life threating complaint(s) 2. Appears - Potentially Unstable (possible Big Sick); ➢ Mental Status and ABCD good but has life threating complaint(s) 3. Appears – Unstable (Big Sick); ➢ Any abnormal Mental Status or abnormal ABCDs and/or has life threating complaint(s) ✓ Inform team of Transport Decision. Stay & Play or Load & Go • **<10 min on scene for Critical patients** ✓ Calls for ALS or any other additional resources that may be needed ✓ Assign Tasks to Team Members (sometimes done in Scene Size up) • EMT #1 - Vital Signs, Patient Treatments and gets gurney setup for patient extrication • EMT #2 - Physical Assessment and Patient History (From patient and bystanders/caregivers) ➢ **Cincinnati Stroke Scale performed for s/s of headache, dizziness, weakness, AMS or dysarthria**		

VITAL SIGNS (Some books place this in the Secondary Assessment) – Should be done On Scene ➢ **Assigns and EMT/EMR to complete if available (for skills practice must complete yourself)** ➢ **The First Set of Vital Signs (Base Line) should be acquired the first few minutes of Patient contact**		
Informs patient of vital signs assessment and get consent (informed/implied) ✓ Checks Vital Signs in uninjured (without Dialysis shunt or on Mastectomy side) extremity ➢ **Must Document Time and Vital Signs (post-it note) – give to lead EMT on Scene**		
Checks patients pulse – ✓ Rate of Beats per Minute - Number of beats in 30 seconds X 2 (1 minute for Slow/Irregular pulses) ✓ Quality – Bounding, Strong, Weak or Absent ✓ Rhythm - Regular or irregular • Must document (even numbers) both rate and quality and rhythm (66 Strong and Regular). If unable to get distal pulses bilaterally then move up to brachial pulse checks.		
Reassesses Skin Signs and Cap Refill ✓ Color - Pink, pale, blue, red, or yellow (check mucus membranes, palms hands/feet) ✓ Temperature - Warm, hot, or cool (check forehead with back of hand) ✓ Moisture - Dry, moist (sweat on palms of hands or forehead), or wet (diaphoretic) Must document all 3 types of assessments (Pink, Warm, Dry) and Cap Refill		
Checks patient's SpO2 – leave SpO2 on patient for the call if unstable or receiving supplemental O2 ✓ Pulse Oximetry heart rate must match patients pulse. Green light or multiple bars on Pulse Oximetry must signal good readings. Many conditions may cause inaccurate readings of the Pulse Oximetry (Skill #1 list). ✓ Document SpO2 as % and if Patient on Oxygen (LPM) or Room Air (RA) ✓ Patient oxygen should be titrated to or above 94% (Hypoperfusion states and hypothermia are exceptions) • SpO2 monitor should be left on all patients that are unstable or patients that are on oxygen		
Checks patient's respirations – ✓ Rate of Breaths per Minute - Number of breaths in 30 seconds X 2 (1 minute for Slow or Irregular breathing) ✓ Quality - Character of breathing (Labored/Non-labored) ✓ Rhythm - Regular or irregular ✓ Noisy respiration or Cough (non/productive (color)) - Normal, stridor, wheezing, snoring, gurgling ✓ Depth - Shallow or deep / Adequate or inadequate tidal volume • Document (even #s) both Rate, Quality and/or Rhythm and/or noise and/or depth (16 Non-labored)		
Checks patient's blood pressure (If BP needs to be repeated let arm rest 1 minute in-between attempts) Document in even numbers ➢ Non-Invasive Blood Pressure can be used AFTER manual Blood pressure but can give Erroneous readings – guideline by NHTSA and manufactures of the NIBP equipment		
Checks patient's pupils P – patient has 2 Pupils E – pupils are Equal A - and R- pupils are Round R – pupil and of Regular size L – pupils react to Light • Must document pupil's reaction (PERL/PEARL/PEARRL, unequal, delayed/sluggish, nonreactive, dilated, pinpoint) – Pupil size not required to be documented by EMTs		
Checks breath sounds in apex & bases bilaterally (**2 breaths per field – under shirt**) ➢ Anterior or Posterior may be assessed (both not required) ➢ EMTs are not required to distinguish lung sounds (Clear, Bad lungs sounds or Absent is all EMTs required to hear). Adventitious lung sounds (rales, rhonchi, wheezes)		
Blood Glucose monitoring in AMS or diabetic patients		
≈If necessary - Other Vital Assessments (Based on State/Local SOP) – End title CO2 detector, CO detector, Temperature		
Student documents vital signs and time taken (Writes down and tells Team Leader)		
Vital signs should be reassessed - Anytime patient condition changes or ✓ Every 5 minutes for critical patients ✓ Every 15 minutes for stable patients		

PATIENT HISTORY - **Investigates the Chief Complaint – Done on Scene and in any order**		
Gathers information from EMRs, bystanders, caregivers, family members and/or the patient • Looks for medical alert tags or information sheets (DNR – POLST Form)		
Obtains SAMPLE History – Done on Scene most of Time		
Signs and symptoms (S/S) that occurred at onset of Complaint (below questions based on Complaint) **Chest or Abdominal Pain Complaints** – Does Patient have signs, symptoms or history of; • Shortness of breath, Dizziness, Weakness or fatigue, Cough, Fever/Chills, Palpitations, Diaphoresis, Difficulty/Pain/blood in Urine, Pedal edema or JVD, Nausea/Vomiting/Diarrhea, Last Bowel movements, Rapid or gradual onset of S/S. Recent illness/trauma/travel history. **Respiratory Distress Complaints** – Does Patient have signs, symptoms or history of; • Chest Pain, Dizziness, Weakness or fatigue, Cough (color of sputum), Fever/Chills, Diaphoresis, Rapid or gradual onset of S/S, Recent illness/trauma/travel, Rash, Pedal edema, JVD, Paroxysmal Nocturnal Dyspnea (PND) or Dyspnea on Exertion (DOE). **Altered Mental Status or Neurological Complaints** – Does Patient have signs, symptoms or history of; • Headache, Dizziness, Vision changes, Seizures, Incontinence, Weakness or fatigue, Fever/Chills or body aches, Rapid or gradual onset of symptoms, Recent illness/trauma history, medication changes. **Allergic Reaction Complaints** – Does Patient have signs, symptoms or history of; • Shortness of breath, Dizziness, Recent exposure, Rash/hives/itching, Swelling of face/neck or oral cavity, Difficulty swallowing, Headache, Rapid or gradual onset of symptoms, Medication changes. **Obstetrics Complaints** – Does Patient have signs, symptoms or history of; • Headache, Dizziness, Vision changes, Swelling of Face or Hands/Feet, under a Doctor's care – Obstetrician (OB), Does she feel urge to push or move her bowels, Are contractions less than 2 or 3 minutes apart, Does she expect multiple babies, Has her water broke (signs of meconium or bleeding), Is she multipara (Para/gravida), History of Drugs or Alcohol, Due Date of the baby, OB complications **Poisoning or Overdose Complaints** – Does Patient have signs, symptoms or history of; • Time and amount of Poison, Decontamination required, Event leading to symptoms, Suicidal thoughts/actions (Police involved), Past history depression/suicide, ETOH or Drug use (search house for medications or containers to take to Hospital), Nausea or vomiting, Patient weight. **Behavioral or Psychiatric Complaints** – Does Patient have signs, symptoms or history of; • Event leading to symptoms, Suicidal/Homicidal thoughts/actions (Police involved), Past history depression/suicide, History of psychiatric holds, ETOH or Drug use or OD (search house for medications), Arm trauma or scars, Nausea or vomiting, Medication changes. Talk to bystanders.		
Allergies to Medications or Food or Latex		
Medications (**dose and how often it is taken**) including Over the Counter, Birth control and ED meds		
Pertinent Past Medical History (diabetes, hypertension, cardiac disease, COPD, asthma) Surgeries, Hospitalizations, ER Visits (where/when/why), Smoking and Recreational Drugs or Alcohol (ETOH)		
Last meal and fluid intake, Last menstrual period or pregnancy for females of childbearing age		
Events associated with the patient's chief complaint – Patient describes what they were doing in a detailed description of the event and what happened right after event		
Gets O.P.Q.R.S.T. questions – Done on Scene most of time		
Onset of Complaint - what was patient doing at time of complaint and has the patient had this before		
Provoke the complaint – does anything make it better or worse (movement, palpation, deep breathing)		
Quality of complaint – use adjectives to describe complaint (sharp, tearing, dull, ache, crushing)		
Radiation – where is the complaint and has it moved or does it radiated to other areas.		
Severity – discomfort scale from 1 – 10 asked to the patient at start of symptoms and currently		
Time – time the event started and is it constant or comes and goes or has it changed		
Gets Patients Demographics and Other Medical History		
Get Patient's Demographical Info (legal name, age, birthday, full address, phone #, insurance/hospital) ✓ Patient ID and Insurance Cards (if at medical facility must get copy of patient's medical record)		
Questions about Recent (days/weeks) Trauma, Travel, Illness, or Hospitalizations (for Medical Records)		
Questions pertinent negatives – does patient have ✓ Chest Pain, Dyspnea, Abdominal Pain, Dizziness, Nausea/Vomiting/Diarrhea, Weakness, Headache		
TRANSPORT DECISION - Stay & Play or Load & Go (<10 min scene time for Critical patients)		
Patient Priority & Transport – may be done at any time in Secondary Physical Assessment. Should consider Transport to Specialized Center (Trauma, Cardiac, L&D, CVA) and Rendezvous with ALS ✓ **Must state When and How the patient is transported - Controlled or Lights and Signs (Code 3)** ✓ Gets Consent from Patient and Transport in Position of Comfort (POC) if possible		

PHYSICAL ASSESSMENT – May be Done on Scene OR Enroute based on the patient status ➢ **Stable Patients may be assessed on scene and unstable patients should be assessed enroute**		
Physical Assessment of the Patient by a Full-Body Scan (Head to Toe Assessment) is required for the skill ***Note - Focused Assessments may be done in the field for some awake and alert patients <u>but not for this skill!</u>*** • **This is done by Inspecting (Looking), Palpating (Feeling), and Auscultation (Listening) – Look before you touch** • **This assessment may be done in any order but often done Head to Toe**		
Assesses patient looking for DCAP-BTLS (Deformities, Contusions, Abrasions, Punctures/ Penetrations, Burns, Tenderness, Lacerations, Swelling) - Informs patient of physical assessment and get consent • Unstable Patient = **Rapid Transport! (Critical Fail!)**		
Head – ✓ Visualize then Palpates Head for deformities (Battles sign/Raccoon eyes) ✓ Visualize Ears and Nose (epistaxis) with light pen for trauma or bleeding ✓ Checks for facial symmetry ✓ Visualize Eyes with light pen for PEARL and checks sclera (redness or jaundice) and conjunctiva ✓ Visualize Airway (opens mouth) and checks for emesis, blood, unusual odors, swelling, or trauma		
Neck – Visualizes Neck for Rash, Scars, JVD, tracheal placement, swelling or subcutaneous emphysema ✓ Visualizes lateral/anterior neck and Palpates cervical vertebrae		
Chest – Gets consent to expose and visualizes under shirt for scars, rash, implanted medical devices, injury or abnormality, subcutaneous emphysema and equal bilateral rise & fall of chest ✓ Palpates clavicles, sternum stress (AP), bilateral rib stress (paradoxical chest wall movement) ✓ **Auscultate Lung Sounds in apices and bases** **≈*If necessary*** - Checks for pleuritic chest pain by movement and deep breaths if patient is awake		
Abdomen – Gets consent to expose and visualizes then Palpates (4 Quadrants) – for scars, rash, implanted medical devices, bruising, tenderness, guarding, rigidity, distention, or masses ➢ Do not palpate abdomen if pain or injury has already been determined		
Back – Gets consent to expose and visualizes under shirt for scars, rash, injury or abnormality ✓ Palpates thoracic/lumbar vertebrae, scapula (both), kidneys (Costovertebral angle), and flank area • Auscultate Lung Sounds in apices and bases if not done yet		
Pelvis – Visualize for incontinence (urine/feces) ✓ Asks patient to moves legs to check range of motion and check for pain		
Arms/Legs – Expose and examine (as necessary- lift pant legs after consent) ✓ Visualize then Palpates all extremities for injury, abnormalities, rash, calf pain or pedal edema ✓ Checks for full range of motion in all extremities in non-trauma patients ✓ Checks CMS* in arms and legs **(Critical Fail!)** *CMS – Circulation, Motor & Sensory function (Neurovascular function or PMS - Pulse/Motor/Sensory)		
≈If necessary - Provides appropriate treatment at appropriate time to patient Medication administration (National Standard of Care) ✓ 5/6 Rights, Med Check Safety Check, Indications, Contraindications, Dose, Route for Medication • Nitroglycerine, Aspirin, Bronchodilators, Activated Charcoal, Oral Glucose, Epinephrine, Narcan ✓ Oxygen and/or CPAP **(Critical Fail!)** (Indications, Contraindications) – (Skill #1) ✓ Bleeding Control **(Critical Fail!)** – (Skill #5) ✓ C-spine immobilization **(Critical Fail!)** – (Skill #4) ✓ Patient Positioning and/or ALS		
≈If necessary - Expose & Examine patient to appropriate level (Age, Mental status, Injury, Environment)		
REASSESSMENT – Done Enroute **–** These should be verbalized and explained		
Repeat the Primary Assessments on the patient		
Reassessment and Recording of Vital Signs – Stable every 15 minutes, Unstable every 5 minutes or if the patient condition changes.		
Reassess chief complaint and Evaluation of Treatments and Interventions provided		
Contacts Hospital/Medical Control and/or documents Standing Orders/Protocols followed		
More than 6 missed points results in Failure Total Missed Points		

✓	Actions performed and/or verbalized by student when doing skill
➢	Additional information on the procedure
•	Key Points that student should know but do not need to verbalized/do unless asked

Evaluator Comments:

Medications in EMT National Scope of Practice

ALL Medications must be in each State Scope of Practice for EMTs to Assist/Administer

Medication	Indications	Contraindications	Dose	Route	Side Affects
Nitroglycerine (Rx) (NTG) National – Yes* CA – Yes** (Rx – Prescription OTC – Over the Counter)	Chest pain, suspected MI or angina Note Patient must be sitting or supine	• Hypotension < 100 systolic • Head injury • **Erectile Dysfunction Medications** (24/48 hours) sildenafil (Viagra), tadalafil (Cialis), or vardenafil (Levitra) or **Pulmonary Hypertensive Medications** – avanafil or riocituat • Brady or Tachycardia - careful	0.3 to 0.4 mg Every 5 minutes up to a maximum of 3 times	Oral (SL)	• Drop in blood pressure (do not repeat if large drop in BP) • Headache • Nausea • Burning under tongue
Aspirin (OTC) (ASA) National – Yes* CA – Yes**	Chest pain, suspected MI	• Allergy to aspirin (Asthma) • Active bleeding • Decreased LOC • No gag Reflex	160/162 mg to 324/325 mg (2 to 4 - 81 mg Aspirin)	Chew oral (PO)	• Abdominal Pain • Nausea and vomiting • GI upset
Bronchodilators (Rx) National – Yes* CA – Yes**	Asthma or difficulty breathing with wheezing	• Suspected AMI	1 – 2 Inhales of MDI	Inhale	• Tachycardia • Hypertension • Tremors/Anxiety • Restlessness
Activated Charcoal (OTC) National – Yes* CA – No, Only Advanced EMT/Paramedic	Oral Poisoning	• Decreased LOC • No gag Reflex • Petroleum, Acids, or Corrosives • Active Vomiting	1-2 grams per Kg 25 grams Pedi 50 grams adults	Oral (PO)	• Nausea and vomiting • Black loose stools
Oral Glucose (OTC) National – Yes CA – Yes**	Diabetic emergencies	• Decreased LOC • No gag Reflex • Nausea and vomiting	1 to 2 tubes (Varies in grams)	Oral	• Possible aspiration if used incorrectly
Epinephrine (Rx) National – Yes CA – Yes**	Anaphylaxis	• Suspected AMI • Hypertension • Hypothermia	.3 - .5 mg May repeat if no relief of symptoms in a few minutes .15 mg for Pedi	IM Auto injector	• Tachycardia • Tremors/Anxiety • Restlessness • Hypertension • Dysrhythmias
Narcan (Rx) National – Yes* CA – Yes**	AMS with decreased respiratory effort and suspected opioid use (Patient may have Pinpoint pupils - miosis)	Considerations to not use • Head Injuries • Hospice Patients or chronic Pain Patients	0.4 mg IM auto injector or 2 mg/4 mg IN	IM Auto injector or IN	• Agitation or Combative • Tachycardia • Pulmonary edema • Nausea/Vomiting • Seizures (withdraw)

*National – Based on National Standard of Care. Does not mean all 50 states allow EMTs to use and/or administer to Patients.

** CA – In CA state Scope of Practice but EMTs need Local EMS Medical Direction to use/give (LEMSA Protocols). May also require additional Training. ALS should be called if EMTs are giving Patient Medications.

Medication Check Safety Flowchart - used by some EMS Systems to decrease Medication errors

EMT #1	Choses medication and calculates the drug dose. EMT #1 States "Med check."
EMT #2	Must then confirm by stating, "Ready."
EMT #1	States the drug name, dose, route and reason for administering.
EMT #2	Considers this information and, if they have no concerns, they ask, "Contraindications?"
EMT #1	Reconsiders possible contraindications. If none are present, they reply, "No contraindications."
EMT #2	Inquiries, "Amount of Medication?"
EMT #1	Shows vial to EMT #2 and state the drug concentration. Shows volume/amount to be administered.
EMT #2	Checks the medication name, concentration, amount and then states, "Sounds good."