Base Hospital Contact: Required for persistent ALOC of unclear etiology.

1. Assess airway and initiate basic and/or advanced airway maneuvers prn (MCG 1302)

2. Administer Oxygen prn (MCG 1302)

3. Assess level of consciousness per MCG 1320

4. Initiate cardiac monitoring (MCG 1308)
   Perform 12-lead ECG if cardiac ischemia suspected and treat in conjunction with TP 1211, Cardiac Chest Pain

5. Establish vascular access (MCG 1375)

6. Check blood glucose
   If < 60mg/dL or > 400mg/dL, treat in conjunction with TP 1203, Diabetic Emergencies

7. For poor perfusion:
   Normal Saline 1L IV rapid infusion
   Reassess after each 250mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops
   For persistent poor perfusion, treat in conjunction with TP 1207, Shock/Hypotension

8. Assess for signs of trauma
   If traumatic injury suspected, treat in conjunction with TP 1244, Traumatic Injury

9. Perform mLAPSS
   If stroke is suspected, treat per TP 1232, Stroke/CVA/TIA

10. For suspected drug overdose or alcohol intoxication, treat in conjunction with TP 1241, Overdose/Poisoning/Ingestion

11. For suspected carbon monoxide exposure, treat in conjunction with TP 1238, Carbon Monoxide Exposure

12. **CONTACT BASE** if the etiology of the ALOC remains unclear
SPECIAL CONSIDERATIONS

❶ Consider all causes of ALOC using a mnemonic AEIOUTIPS:

A – Alcohol, abuse, atypical migraine
E – Epilepsy, electrolytes
I – Insulin (hypoglycemia)
O – Oxygen, overdose
U – Uremia (kidney failure)
T – Trauma, tumor
I – Infection
P – Psych, poisoning
S – Seizure, Subarachnoid hemorrhage, Sepsis, Stroke

Once the cause for ALOC is determined, switch to the more specific protocol.

❷ Consider narcotic overdose for patients with hypoventilation (bradypnea), and pinpoint pupils, drug paraphernalia, or strong suspicion of narcotic use.