

Base Hospital Contact: Required for persistent ALOC of unclear etiology. ①

1. Assess airway and initiate basic and/or advanced airway maneuvers per *(MCG 1302)*
2. Administer **Oxygen** per *(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 ②*
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

- ① 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.

- ② Consider narcotic overdose for patients with hypoventilation (bradypnea), and pinpoint pupils, drug paraphernalia, or strong suspicion of narcotic use.