Medical Control Guideline: LEVEL OF CONSCIOUSNESS

PRINCIPLE:

1. Evaluation and documentation of the patient's level of consciousness are key components of a thorough patient assessment.

2. The patient's baseline level of consciousness should be taken into consideration when evaluating whether the altered level of consciousness (ALOC) finding represents an acute change or is normal for the patient.

3. Signs and symptoms of ALOC may present as disorientation to person, place or time; confusion; lethargy; impaired cognition; coma; inappropriate aggressiveness; or hostility. These findings should alert EMS personnel to the possibility that the patient may have a serious underlying medical condition.

4. If the patient has ALOC, evaluation of past medical history, including history of ALOC reported by patient or family members, may provide clues to the cause of the patient's ALOC.

GUIDELINES:

1. Assess orientation by asking the patient the following:
   a. Name
   b. Where they live/where they are
   c. Day of week/year/time of day

   Patients unable to reasonably answer one or more of the above shall be considered to have ALOC.

2. Utilize the appropriate Glasgow Coma Scale (GCS) to assess the neurological status of all patients. Report and document the GCS in the following order: eye opening, verbal response, and motor response.

	Adult	Child (1-4 yrs.)	Infant
EYE OPENING			
4	Spontaneous	Spontaneous	Spontaneous
3	To voice	To voice	To shout
2	To pain	To pain	To pain
1	None	None	None
VERBAL RESPONSE			
5	Oriented	Oriented	Smiles and coos appropriately
4	Confused	Confused	Cries and consolable
3	Inappropriate	Inappropriate	Persistent inappropriate crying and/or screaming
2	Incomprehensible	Incomprehensible	Grunts or is agitated or is restless
1	None	None	None
MOTOR RESPONSE			
6	Obedient	Obeys command	Spontaneous
5	Purposeful	Localizes to pain	Localizes to pain
4	Withdraws to pain	Withdraws to pain	Withdraws to pain
3	Flexion (decorticate)	Flexion (decorticate)	Flexion (decorticate)
2	Extension (decerebrate)	Extension (decerebrate)	Extension (decerebrate)
1	None	None	None

NOTE: For patients unable to communicate or patients with a language barrier, estimate appropriateness of motor response, obedience, and verbal response by consulting with the family and/or primary caregiver(s), if applicable.

3. If the patient has ALOC consider possible causes using AEIOU-TIPS:

   A – Alcohol, abuse of substances
   E – Electrolytes
   I – Infection
   O – Oxygen (hypoxia), overdose
   U – Uremia
   T – Trauma, tumor, child maltreatment, toxic substance (or adverse reactions to medications
   I – Insulin (hypoglycemia)
   P – Poisoning, Psych
   S – Seizures, Sepsis, Stroke, Subarachnoid Hemorrhage

4. Perform an on scene assessment, obtain history from caregivers including baseline functional status, and complete physical assessment including neurological exam to evaluate patient for signs of stroke.

5. Point of care testing should include pulse oximetry, glucose testing, and cardiac monitoring to include 12-lead ECG in patients with suspected cardiac ischemia or dysrhythmia.