

ALS MEDICAL EMERGENCIES



ALLERGIC REACTIONS
ALTERED MENTAL STATUS
DIABETIC EMERGENCIES
DYSTONIC REACTION
FLUID RESUSCITATION
HYPERKALEMIA
NAUSEA/VOMITING
RESPIRATORY DISTRESS
SEIZURES
SEPSIS
STROKE

ALLERGIC REACTION



INFORMATION

S/S: Allergic reactions are characterized by any of the following: urticaria, mild respiratory distress, difficulty swallowing, or swelling of the tongue and/or face.



ADULT

FOR GENERALIZED URTICARIA ONLY

BENADRYL: 50mg IV/IO/IM. Administer over 2 minutes for IV/IO usage. (See Box Below)

FOR MILD AIRWAY SWELLING / MILD RESPIRATORY DISTRESS / BRONCHOSPASM / TONGUE AND/OR FACIAL SWELLING

EPINEPHRINE: (1:1,000) 0.3mg (0.3mL) IM. May repeat 2x prn in five minute intervals.

- *Do not administer within 5 minutes of Epi-Pen administration*

BENADRYL: 50mg IV/IO/IM. Administer over 2 minutes for IV/IO usage. (See Box Below)

ALBUTEROL: For bronchospasm, 2.5mg via nebulizer, repeat prn.

ANAPHYLACTIC SHOCK - CHARACTERIZED BY THE SIGNS AND SYMPTOMS OF AN ALLERGIC REACTION, IN ADDITION TO THE LOSS OF A RADIAL PULSE AND/OR SBP OF LESS THAN 90mmHg

Establish a second IV/IO.

EPINEPHRINE: (1:10,000) 0.1mg (diluted in 9mL of Saline), IV/IO over 1-2 minutes. May repeat 2x prn, in five minute intervals. Max total dose 0.3mg (See Box Below)

If patient remains hypotensive: **NORMAL SALINE**: 1-2L. Assess lung sounds and BP every 500 mL.

Administer **BENADRYL** and **ALBUTEROL** as noted above.

Contact medical control, if necessary, for additional orders of **EPINEPHRINE (1:10,000)** and fluid boluses.

BENADRYL ADMINISTRATION IV/IO: Dilute with 9 mL of Normal Saline.

Discard 9 mL of Epi 1:10,000 and draw up 9 mL of Normal Saline and administer over 1-2 minutes. You may repeat 2x prn, in five minute intervals.



PEDIATRIC

FOR GENERALIZED URTICARIA ONLY

- BENADRYL:** 1mg/kg IV/IO *or* IM if unable to obtain IV access. Max total dose 50mg. Administer over 2 minutes for IV/IO usage. (See Box Below)

FOR MILD AIRWAY SWELLING / MILD RESPIRATORY DISTRESS / BRONCHOSPASM / TONGUE AND/OR FACIAL SWELLING

- EPINEPHRINE:** (1:1,000) 0.01mg/kg (0.01mL/kg) IM. Max single dose 0.3mg. May repeat 2x prn, in 5 minute intervals.
- BENADRYL:** 1mg/kg IV/IO *or* IM if unable to obtain IV access. Max total dose 50mg. Administer over 2 minutes for IV/IO usage. (See Box Below)
- ALBUTEROL:** For bronchospasm, 2.5mg via nebulizer, repeat prn.

ANAPHYLACTIC SHOCK - CHARACTERIZED BY THE SIGNS AND SYMPTOMS OF AN ALLERGIC REACTION, IN ADDITION TO THE LOSS OF DISTAL PULSES

- Establish a second IV/IO.
- EPINEPHRINE:** (1:10,000) 0.1mg (diluted in 9mL of Saline), titrate slowly over 5-10 minutes IV/IO (titrate to effect). May repeat 2x prn, in five minute intervals. (See Box Below)
- If patient remains hypotensive: **NORMAL SALINE:** 20mL/kg bolus IV/IO, may repeat 2x prn for hypotension. Check lung sounds often.
- Administer **BENADRYL** and **ALBUTEROL** as noted above.
- Contact medical control if necessary for additional fluid boluses.

BENADRYL ADMINISTRATION IV/IO: Dilute with 9 mL of Normal Saline.

Discard 9 mL of Epi 1:10,000 and draw up 9 mL of Normal Saline and administer over 5-10 minutes (titrate to effect). You may repeat 2x prn, in five minute intervals.

ALTERED MENTAL STATUS



INFORMATION

Consider the possible causes: AEIOU-TIPS, meningitis, and/or dehydration.



ADULT & PEDIATRIC



AEIOU-TIPS

- A Alcohol
- E Epilepsy (Seizures)
- I Insulin (Hyper/Hypoglycemic)
- O Overdose (and Oxygenation)
- U Uremia (Kidney Failure)

- T Trauma
- I Infection (Sepsis)
- P Psychiatric (and Poisoning)
- S Stroke (and Shock)

DIABETIC EMERGENCIES



INFORMATION

Symptoms of DKA include: nausea/vomiting, abdominal pain, general weakness, Kussmaul Respirations, AMS, hypotension, or tachycardia with an acetone smell on the patient's breath.



ADULT

IF BLOOD GLUCOSE IS LESS THAN 60 mg/dL

- ORAL GLUCOSE:** (15g) May be given if patient is able to swallow and follow commands. May repeat 1x prn.
- D10:** 100 mL IV, retest glucose. If patient remains less than 60 mg/dL, administer another 100 mL of D10.

IF UNABLE TO OBTAIN IV ACCESS

- Perform Proximal Humerus IO and administer **D10:** 100mL, retest glucose. If patient remains less than 60 mg/dL, administer another 100 mL of D10.

IF BLOOD GLUCOSE LEVEL IS GREATER THAN 300 mg/dL WITH S/S OF DKA

- NORMAL SALINE:** 1-2L. Assess lung sounds and blood pressure every 500mL.
- ZOFRAN:** 4mg IM or slow IV/IO/PO over 2 minutes for nausea/vomiting.

Patients taking oral hypoglycemic mediations should be transported to the ED regardless of post treatment glucose levels. (i.e. Glyburide, Glimepiride, and Glipizide)

IF UNABLE TO PROVIDE ABOVE TREATMENT

- GLUCAGON:** 1mg IN or IM if available.
 - Glucagon may cause nausea/vomiting.
- ZOFRAN:** 4mg IM/PO for nausea/vomiting.



PEDIATRIC

IF BLOOD GLUCOSE LEVELS ARE LESS THAN 60 mg/dL

- ORAL GLUCOSE: (15g) may be given to conscious patients with an intact gag reflex.
 - *Not recommended for patients less than 2 years old.*
- D10: 5ml/kg IV/IO (max of 100 mL), retest glucose. May repeat 1x prn.

IF BLOOD GLUCOSE LEVELS ARE GREATER THAN 300 mg/dL with S/S of DKA

- NORMAL SALINE: 20mL/kg IV/IO. Assess lung sounds and blood pressure often.
- ZOFRAN: 0.1mg/kg IM or slow IV/IO/PO for nausea/vomiting. Max dose 4mg.

IF UNABLE TO PROVIDE ABOVE TREATMENT

- GLUCAGON: Less than 20kg (0.5mg IM or IN), greater than 20kg (1mg IM or IN) if available.
 - *Glucagon may cause nausea/vomiting.*
- ZOFRAN: 0.1mg/kg IM or slow IV/IO/PO for nausea/vomiting. Max dose 4mg.

DYSTONIC REACTION



INFORMATION

Dystonic reactions are characterized by intermittent spasmodic or sustained involuntary contractions of muscles in the face, neck, trunk, pelvis, extremities, and even the larynx. Typically, antipsychotic (Haldol, Lithium, etc.), antiemetic (Compazine, Reglan, etc.) or antidepressant (Prozac, Paxil etc.) medications are responsible. A dystonic reaction can occur immediately or be delayed for hours to days.



ADULT

BENADRYL : 50mg IV/IO/IM. Administer over 2 minutes for IV/IO usage. (See Box Below)



PEDIATRIC

BENADRYL: 1mg/kg IV/IO *or* IM if unable to obtain IV access. Max total dose 50mg. Administer over 2 minutes for IV/IO usage. (See Box Below)

BENADRYL ADMINISTRATION IV/IO: Dilute with 9 mL of Normal Saline.

FLUID RESUSCITATION



INFORMATION

For dehydration secondary to: prolonged vomiting and/or diarrhea, DKA, heat illness, pneumonia, non-traumatic bleeding (vaginal or GI), or hypotension secondary to overdose/poisoning.



ADULT

NORMOTENSIVE WITH S/S OF DEHYDRATION OR NON-TRAUMATIC BLEEDING

- NORMAL SALINE: 1-2L. Assess lung sounds and blood pressure every 500mL.

IF PATIENT IS HYPOTENSIVE (SBP LESS THAN 90mmHg)

- NORMAL SALINE: 1-2L. Assess lung sounds and blood pressure every 500mL.

IF PATIENT REMAINS HYPOTENSIVE AFTER FLUID ADMINISTRATION OR DEVELOPS PULMONARY EDEMA

- DOPAMINE: 5-20mcg/kg/min. Titrate and maintain a SBP of 90 mmHg.



PEDIATRIC

NORMOTENSIVE WITH S/S OF DEHYDRATION

- NORMAL SALINE: 20mL/kg IV/IO. Assess lung sounds and blood pressure often.

IF PATIENT IS HYPOTENSIVE

- NORMAL SALINE: 20mL/kg bolus IV/IO, may repeat 2x prn for continued hypotension. Assess lung sounds and blood pressure often.

NOTES

- Consider sepsis for all dehydrated patients.
- Patients with a history of renal failure/dialysis or CHF are at increased risk for fluid overload. Monitor these patients carefully.

HYPERKALEMIA



INFORMATION

Consider hyperkalemia in patients with a history of renal failure/dialysis who are pre-dialysis and present with: general weakness, hypotension, paresthesia, tall peaked T-waves (most prominent early sign), or arrhythmias (sine wave, wide complex QRS, V-Tach, severe bradycardia, or high degree AV blocks)



ADULT

FOR PATIENTS PRESENTING WITH ANY OF THE ABOVE ARRHYTHMIAS

- ALBUTEROL: 2.5mg via nebulizer, continuous treatments.
- CALCIUM CHLORIDE: 1 gram, slow IV/IO over 2 minutes.
- SODIUM BICARBONATE: 50 mEq, slow IV/IO over 2 minutes.
- If patient is intubated, administer Albuterol via BVM.

Do not administer Calcium Chloride and Sodium Bicarbonate in the same IV line without thoroughly flushing the IV.

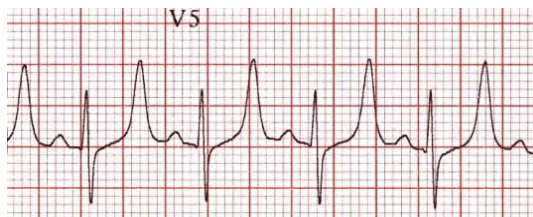
IF PATIENT IS HYPOTENSIVE

Administer **NORMAL SALINE**: 500mL, may repeat 1x prn. Check lung sounds after each fluid bolus.



PEDIATRIC

- Call for Orders.



Peaked T wave



Sine Wave

NAUSEA/VOMITING



INFORMATION

Consider differential diagnosis: MI, Stroke, Diabetic, Head Injury, etc.



ADULT

IF PATIENT IS NORMOTENSIVE

- NORMAL SALINE: 1-2L. Assess lung sounds and blood pressure every 500mL.
- ZOFRAN: 4mg IM or slow IV/IO/PO (See box below). Can be administered prn.

IF PATIENT IS HYPOTENSIVE

- NORMAL SALINE: 1-2L. Assess lung sounds and blood pressure every 500mL.
- ZOFRAN: 4mg IM or slow IV/IO/PO (See box below). Can be administered prn.



PEDIATRIC

IF PATIENT IS NORMOTENSIVE

- NORMAL SALINE: 20mL/kg bolus. Assess lung sounds often.
- ZOFRAN: 0.1mg/kg IM or slow IV/IO/PO (See box below). Can be administered prn. Max dose 4mg.

IF PATIENT IS HYPOTENSIVE

- NORMAL SALINE: 20mL/kg bolus. May repeat 2x prn for continued hypotension. Assess lung sounds and blood pressure often.
- ZOFRAN: 0.1mg/kg IM or slow IV/IO/PO (See box below). Can be administered prn. Max dose 4mg.

ZOFRAN ADMINISTRATION: If IV access is unobtainable, it is acceptable to administer the IV formulation of Zofran via the PO route to the patient. Using a needleless syringe administer the Zofran under the patient's tongue.



INFORMATION

Patients with COPD & Asthma have prolonged exhalation secondary to bronchospasm, which causes air trapping resulting in hypercapnia (high levels of CO₂). Therefore, EtCO₂ guidelines should be disregarded for these patients, as it is more important to maintain SpO₂ levels at 90%. Trying to maintain normal EtCO₂ levels in these patients puts them at risk for developing Auto PEEP, which can result in a pneumothorax or hypotension. Auto PEEP occurs during assisted ventilations when air goes in before the patient is allowed to fully exhale. This causes the lungs to expand like a balloon, putting the patient at risk for a pneumothorax. In addition, increasing intrathoracic pressure decreases venous return to the heart which can result in hypotension.

COPD or Asthma patients who develop poor bag compliance or hypotension during positive pressure ventilations should have positive pressure ventilations discontinued (if intubated, disconnect BVM from ETT) for 20-40 seconds (10-20 seconds for pediatrics) to allow the patient to completely exhale before resuming positive pressure ventilations.



ADULT

- Consider differential diagnosis (i.e. CHF, allergic reaction, etc.).
- Maintain SpO₂ at 95% or 90% for COPD and asthma patients.
- Provide ventilatory support prn.
- Monitor EtCO₂ (if available).
- CPAP (10 cm H₂O) is indicated for moderate/severe respiratory distress, including: COPD, asthma and pneumonia patients.
 - *Contraindicated for a SBP less than 90mmHg*
 - *Contraindicated for patients without spontaneous respirations*
 - *Contraindicated for patients with a decreased LOC (lethargic)*
 - *Only for patients 30kg or above*

IMMEDIATELY REMOVE THE CPAP FOR THE ASTHMATIC PATIENT WHOSE CONDITION WORSENS AFTER APPLYING THE CPAP.

ADMINISTER IN-LINE NEBULIZED ALBUTEROL TO ALL INTUBATED ASTHMA PATIENTS WITH BRONCHOSPASM.



ADULT

BRONCHOSPASM SECONDARY TO COPD

- ALBUTEROL:** 2.5mg via nebulizer. May be administered simultaneously with CPAP. Repeat prn for bronchospasm.

BRONCHOSPASM SECONDARY TO ASTHMA

- ALBUTEROL:** 2.5mg via nebulizer. May be administered simultaneously with CPAP. Repeat prn for bronchospasm.
- If bronchospasm worsens or fails to improve after Albuterol Treatment:
EPINEPHRINE: (1:1,000) 0.3mg IM. May repeat 2x in five minutes.

FOR SEVERE ASTHMA NOT RESPONDING TO ABOVE TREATMENT

- MAG SULFATE:** 2g IV/IO in 50 mL of Normal Saline over 10 minutes.



PEDIATRIC

BRONCHOSPASM

- Oxygenate and/or ventilate prn to maintain SpO₂ at 95% and EtCO₂ levels between 35-45 mmHg. Treatment for asthma patients is based on maintaining an SpO₂ of 90%.
- ALBUTEROL: 2.5mg via nebulizer. Repeat prn for bronchospasm.

IF BRONCHOSPASM WORSENS AFTER ABOVE ALBUTEROL TREATMENT

- EPINEPHRINE: (1:1,000) 0.01mg/kg (0.01mL/kg) IM. Max single dose 0.3mg. May repeat 2x prn, in five minute intervals.

FOR SEVERE ASTHMA NOT RESPONDING TO ABOVE TREATMENT

- MAGNESIUM SULFATE: 40 mg/kg in 50 mL of Normal Saline infused over 25 minutes.
- ASSIST VENTILATIONS via BVM prn with appropriate airway adjunct.

FOR CROUP/EPIGLOTTITIS

- EPINEPHRINE: (1:1,000) 3mL (3mg total) delivered via nebulizer.
- DO NOT STRESS THE PATIENT!
- DO NOT ATTEMPT INTUBATION OR PLACE AN OPA OR NPA. VENTILATE VIA BVM AS NEEDED.
- Expedite transport to closest approved Pediatric Emergency Facility.

CROUP

- Usually less than 3 y/o
- "Sick" for a couple of days
- Low grade fever
- Not "toxic" appearing

EPIGLOTTITIS

- Usually 3-6 y/o
- Sudden Onset
- High grade fever
- Poor general impression
- Drooling
- Tripod position

Both will have stridor and/or a "barky" cough.



INFORMATION

Consider the possible causes: meningitis, head trauma, hemorrhagic stroke, diabetic, drugs, alcohol, poisoning, fever, and eclampsia.



ADULT

IF ACTIVELY SEIZING

- VERSED: 2.5 mg IV/IO **OR** 5mg IN/IM. May repeat either route 1x prn.



PEDIATRIC

FEBRILE SEIZURES

- Actively cool the patient by removing the clothing and fanning, being careful not to induce shivering.
- DO NOT cover patient with a wet towel/sheet.
- DO NOT apply ice/cold packs to the patient's body.

IF ACTIVELY SEIZING, FEBRILE OR NON-FEBRILE

- VERSED: 0.1mg/kg IV/IO (max single dose 2.5mg) **OR** 0.2 mg/kg IN/IM (max single dose of 5mg). May repeat either route 1x prn.



INFORMATION

Recognition and treatment of sepsis is the key to the successful management of sepsis. It is imperative once sepsis is identified, that the patient is kept from becoming hypotensive, as an episode of hypotension significantly increases morbidity and mortality. Sepsis is most common in the elderly, very young, patients confined to bed (bed sores, abscesses, cellulitis, or immobile) and patients with a recent history of surgery or an invasive medical procedure.

SEPSIS CRITERIA

- Adult and **NOT** pregnant **WITH**
- Suspected or documented infection **AND**
- At least **two** SIRS (Systemic Inflammatory Response Syndrome) criteria:
 - Pulse greater than 90
 - Respirations greater than 20
 - Temperature greater than 100.4°F or less than 96.8°F

SEVERE SEPSIS CRITERIA

- Patient has met the above Sepsis Criteria **AND**
- Hypoperfusion as manifested by any **one** of the following:
 - SBP less than 90mmHg
 - DBP less than 60mmHg
 - Mean Artrial Pressure (MAP) of less than 70
 - Altered Mental Status
 - EtCO₂ Equal to or less than 25mmHg

SEPTIC SHOCK CRITERIA

- Patient has met the above Severe Sepsis Criteria **AND** remains hypotensive after initial fluid resuscitation of 2L.

Two SIRS Criteria and One Hypoperfusion Criteria = SEPSIS ALERT

SUSPECTED INFECTION (EXAMPLES)

- Fever
- UTI (Increased urinary frequency, dysuria, and/or cloudy, bloody, or foul smelling urine)
- Pneumonia (productive cough, green/yellow/brown sputum)
- Wounds or insertion sites that are: painful/red/swollen or have a purulent (pus) discharge
- Patient is on antibiotics
- Recent history of surgery/invasive medical procedure (eg. Foley Catheter, Central Lines, etc.)
- AMS and/or poor oral intake of the past 24-48 hours (especially in the elderly)



ADULT

SEPSIS TREATMENT

- Monitor EtCO₂
- BGL
- Maintain SpO₂ at 95% or 90% for COPD and asthma patients.
- NORMAL SALINE:** 1L, *regardless* of blood pressure. Assess lung sounds every 500mL.

SEVERE SEPSIS *OR* SEPTIC SHOCK TREATMENT

- Call a Sepsis Alert and limit on-scene time
- Monitor EtCO₂
- BGL
- Maintain SpO₂ at 95% or 90% for COPD and asthma patients.
- NORMAL SALINE:** 2L, *regardless* of blood pressure. Assess lung sounds every 500mL.
- If patient develops rales *OR* is unable to tolerate the fluid challenge: **DOPAMINE:** 5-20 mcg/kg/min IV/IO, titrate to maintain a SBP of 90mmHg or a MAP greater than or equal to 70.

Patients with a history of renal failure or CHF may not tolerate fluids. These patients should be monitored carefully for the development of rales.



PEDIATRIC

- NORMAL SALINE:** 20mL/kg IV/IO bolus. Assess lung sounds and blood pressure often. May repeat 1x prn.



INFORMATION

R.A.C.E. (Risk Assessment of Cerebrovascular Events) **IF ANY SCORE** greater than a zero is found during the assessment, call a stroke alert, expedite transport, notify the hospital ASAP and advise that this is a “Stroke Alert” and include the R.A.C.E exam score. **Determine to the best of your ability the exact time of stroke onset or the last known well time of the patient. Obtain witness information to include: names, phone numbers, and medications. Then relay the information to the ED. Onset of Stroke symptoms must be within 24 hours to call a Stroke Alert.**

ITEM	INSTRUCTION	R.A.C.E. SCORE
Facial Palsy	Ask the patient to show their teeth: “Smile”	0 – Absent (symmetrical movement) 1 – Mild (slightly asymmetrical) 2 – Moderate to Severe (completely asymmetrical)
Arm Motor Function	Extend the arm of the patient 90 degrees (if sitting) or 45 degree (if supine) palms up	0 – Normal to mild (limb upheld more than 10 seconds) 1 – Moderate (limb upheld less than 10 seconds) 2 – Severe (patient unable to raise arm against gravity)
Leg Motor Function	Extend the leg of the patient 30 degrees (if supine) one leg at a time	0 – Normal to mild (limb upheld more than 5 seconds) 1 – Moderate (limb upheld less than 5 seconds) 2 – Severe (patient unable to raise leg against gravity)
Head and Eye Gaze Deviation	Observe range of motion of eyes and look for head turning to one side.	0 – Absent (normal eye movement to both sides, and no head deviation was observed) 1 – Present (eyes and/or head deviation to one side was observed)
Aphasia If patient has Right sided weakness	Ask the patient to follow two verbal orders: “Close your eyes” and “Make a fist”	0 – Normal (performs both tasks correctly) 1 – Moderate (performs one task correctly) 2 – Severe (performs neither task)
Agnosia If patient has Left sided weakness	Ask the patient: “Who’s arm is this?” when showing him or her the weak arm or “Can you move your arm?”	0 – Normal appropriate or correct answer 1 – Moderate (either does not recognize limb or states that they can move it but can’t) 2 – Severe (both of them)
	*Head/Eye Gaze Deviation or if patient is mute and does not follow commands = High likelihood of a large vessel occlusion	R.A.C.E. SCALE TOTAL: Max Score of 9

Only assess Aphasia if the patient has Right sided weakness and only assess Agnosia if the patient has Left sided weakness. You never perform both during this evaluation.

Consider differential diagnosis: **Must check BGL, Inspect for Head Trauma, Bell’s Palsy etc...**



ADULT

- Transport patient in a supine position, unless patient is short of breath or is an interfacility transport with a diagnosis of intracerebral hemorrhage (ICH - see below).
- 2 Lpm NC regardless of pulse oximetry reading. Increase oxygen therapy as needed.
- An 18g catheter in the antecubital is preferred.
- Normal Saline: 500mL bolus (Regardless of BP).
- Complete the Stroke Alert Criteria Check List to determine if patient meets stroke alert criteria.
- Transport to the closest Primary Stroke Center only if all of the following are met:
 - Transport time is greater than 20 minutes to a Comprehensive Stroke Center **AND**
 - Onset of symptoms is less than 3.5 hours **AND**
 - The patient is not complaining of a severe headache **AND**
 - There are no tPA exclusions
- All other Stroke Alerts shall be transported to a Comprehensive Stroke Center.
- All **STROKE ALERTS** shall be transported priority 2.
- The time of onset is determined to be the time that the patient was last seen to be normal (without stroke signs and symptoms).
- Any patient who awakens with stroke symptoms or when it is not able to be determined when stroke symptoms began shall be transported to an approved Comprehensive Stroke Center as a stroke alert.

tPA EXCLUSIONS

- Onset of stroke symptoms greater than 3.5 hours
- Seizure prior to stroke symptoms
- Prior stroke or serious head injury within the previous 3 months
- Major Surgery within 14 days
- Known history of intracranial hemorrhage
- Gastrointestinal or urinary tract bleeding within 21 days.
- Patients currently taking blood thinners (Aspirin is not considered a blood thinner).

INTERFACILITY TRANSPORTS WITH ICH (Intracerebral Hemorrhage)

- All patients transported with a diagnosis of intracerebral hemorrhage (ICH) must be transported in a 30 degrees elevation. **DO NOT LAY THESE PATIENTS SUPINE.**



PEDIATRIC

- Transport patient in a supine position, unless patient is short of breath.
- 2 Lpm NC regardless of pulse oximetry reading. Increase oxygen therapy as needed.
- An appropriately sized IV catheter. The antecubital is the preferred IV access site.
- Normal Saline:** 10 mL/kg bolus (max 250 mL) (Regardless of BP).
- Complete the Stroke Alert Criteria Check List to determine if patient meets stroke alert criteria.
- Transport All suspected Pediatric Strokes to St. Mary's Comprehensive Stroke Center.
- All **STROKE ALERTS** shall be transported Priority 2.
- The time of onset is determined to be the time that the patient was last seen to be normal (without stroke signs and symptoms).
- Any patient who awakens with stroke symptoms or when it is not able to be determined when stroke symptoms began shall be transported to St. Mary's Comprehensive Stroke Center as a stroke alert.

tPA EXCLUSIONS

- Onset of stroke symptoms greater than 3.5 hours
- Seizure prior to stroke symptoms
- Prior stroke or serious head injury within the previous 3 months
- Major Surgery within 14 days
- Known history of intracranial hemorrhage
- Gastrointestinal or urinary tract bleeding within 21 days.
- Patients currently taking blood thinners (Aspirin is not considered a blood thinner).