

Envenomation

History <ul style="list-style-type: none"> •Type of sting/bite •Description of animal involved •Time, location, size of bite/sting •Previous reaction •Domestic vs. wild •Tetanus and rabies risk •Infection risk •Immunocompromised patient 	Physical <ul style="list-style-type: none"> •Rash, skin break, wound •Pain, soft tissue swelling, redness •Blood oozing from wound •Evidence of infection •Shortness of breath, wheezing •Allergic reaction •Hypotension 	Differential Diagnoses <ul style="list-style-type: none"> •Animal bite •Human bite •Snake bite •Spider bite •Insect sting •Anaphylaxis
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B	Universal Care Protocol	B
B	Refer to allergic reaction protocol if needed.	B
B	Minimize activity, remove tight clothing or jewelry, immobilize extremity at level of heart.	B
B	For exotic animals (Coral snakes, cobra's), contact Poison Control. Do not delay transport.	B
EN	IV Procedure	EN
I/P	Consider morphine 2-4 mg IV, up to a total of 10 mg for pain.	I/P
MC	Dopamine 2 to 20 mcg/kg/min IV infusion for hypotension unresponsive to fluid therapy.	MC

Pearls:

Signs of pit viper envenomation are swelling that begins at the bite mark and spreads proximally within minutes, ecchymosis, hemorrhagic blisters, and severe pain.

Avoid using constricting bands or tourniquets, cold application, incision, suction, and extractor devices in pit viper envenomations.

Black widow spider envenomations may present with painful muscle spasms.
Blue Ridge Poison Center 434-924-5543 or 1-800-451-1428

Hyperthermia

History	Physical	Differential Diagnoses
<ul style="list-style-type: none">•Age•Exposure to increased temperature or humidity•Past medical history/ medications•Extreme exertion•Time and length of exposure•Poor PO intake•Fatigue•Muscle cramping	<ul style="list-style-type: none">•Altered mental status•Hot, dry or sweaty•Hypotension•Seizures•Nausea	<ul style="list-style-type: none">•Fever•Dehydration•Medications•Hyperthyroidism•Delirium tremens•Heat cramps•Heat exhaustion•Heat stroke•CNS lesions or tumors

Pearls:

Tricyclic antidepressants, phenothiazines, anticholinergics, and alcohol predispose patients to hyperthermia.

Cocaine, amphetamines, and salicylates may elevate body temperature.

The major difference between heat exhaustion and heat stroke is CNS impairment. Avoid dramatic decreases in temperature which can cause shivering and increase temperature.

Dehydration and volume depletion may not occur in classic stroke. Vigorous fluid administration may result in pulmonary edema, particularly in the elderly.

Hyperthermia

B	Universal Care Protocol	B
B	Move to cooler environment, remove excess clothing, protect from further heat gains.	B
B	For heat exhaustion, PO water if patient can tolerate. Cool with wet towels or fans.	B
B	For heat stroke, use aggressive evaporation (fine mist water spray, ice packs to groin and axillae).	B
EN	IV Procedure	EN

Hypotension (Symptomatic)

History <ul style="list-style-type: none"> •Blood loss •Fluid loss •Infection •Cardiac ischemia •Medications •Allergic reaction •Pregnancy •History of poor oral intake 	Physical <ul style="list-style-type: none"> •Restlessness, confusion •Weakness, dizziness •Weak, rapid pulse •Pale, cool, clammy skin •Delayed capillary refill •Coffee-ground emesis •Tarry stools 	Differential Diagnoses <ul style="list-style-type: none"> •Shock <ul style="list-style-type: none"> Hypovolemic Cardiogenic Septic Neurogenic Anaphylactic •Ectopic pregnancy •Dysrhythmias •Pulmonary embolism •Tension pneumothorax •Medication effect •Vasovagal •Physiological (pregnancy)
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B	If anaphylaxis, refer to Severe Allergic Reaction protocol	B
EN	IV Procedure	EN
IP	Dopamine 5-20 mcg/kg/min to maintain BP >90 mmHg if no response to IV therapy or if CHF is present.	IP

Pearls:

Hypovolemia must be corrected prior to dopamine infusion.
 Identify and manage underlying cause.
 Consider drug side effects or overdose.

Hypothermia

History	Physical	Differential Diagnoses
<ul style="list-style-type: none">•Past medical history•Medications•Exposure to environment, even in normal temperatures•Exposure to extreme cold•Extremes of age•Drug use•Infections/ sepsis•Length of exposure/witness	<ul style="list-style-type: none">•Cold, clammy•Shivering•Altered mental status•Extremity pain or sensory abnormality•Bradycardia•Hypotension	<ul style="list-style-type: none">•Sepsis•Environmental exposure•Hypoglycemia•CNS dysfunctionStrokeHead injurySpinal cord injury

Pearls:

If patient is centrally cold to touch, consider severely hypothermic.

Avoid rough handling.

Warm fluids as close to 109° as possible by placing on heater or hot packs. Do not microwave.

Avoid intubation if possible in the severely hypothermic patient.

Consider "urban hypothermia" with high association of poverty or drug/alcohol abuse.

Hypothermia

B	Universal Care Protocol	B
B	Refer to Special Arrest: Hypothermic Arrest Protocol if needed	B
B	Remove wet garments.	B
B	Protect from further heat loss. Increase ambient temperature.	B
B	Apply heat packs if patient is responsive.	B
B	If moderate to severely hypothermic, wrap head and core with blankets.	B
EN	Airway management	EN
EN	IV Procedure	EN

Near Drowning

History <ul style="list-style-type: none"> •Submersion in water •Associated trauma •Duration of immersion •Temperature of water •Fresh vs. salt water •Contamination of water 	Physical <ul style="list-style-type: none"> •Unresponsive •Altered mental status •Decreased vital signs •Vomiting •Cough •Aspiration 	Differential Diagnoses <ul style="list-style-type: none"> •Trauma •Pre-existing medical problem •Pressure injury barotrauma decompression sickness
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B	Remove from water if trained and safe to do so.	B
B	Spinal immobilization if indicated.	B
B	Prevent heat loss, refer to "Hypothermia" protocol if indicated.	B
EN	IV Procedure	EN
I/P	Refer to specific cardiac arrhythmias protocol as needed.	I/P

Pearls:

Most near drowning victims will be hypothermic to some extent.
 Assess type of incident (surface impacted, object strike, propeller trauma).
 Assess water conditions (depth of submersion, length of time).
 Monitor airway status closely.

Could CPAP be considered here?

Poisoning/ Overdose

History	Physical	Differential Diagnoses
<ul style="list-style-type: none">•Ingestion of toxic substance•Route and quantity of ingestion•Time of ingestion•Reason (suicide, accident)•Available medications near patient•Past medical history•Medications•Illicit drug abuse	<ul style="list-style-type: none">•Altered mental status•Hypotension•Decrease respiratory rate•Tachycardia•Dysrhythmias•Seizures	<ul style="list-style-type: none">•Tricyclic antidepressants•Acetaminophen•Depressants•Stimulants•Anticholinergics•Cardiac medications•Solvents, cleaning agents•Insecticides (organophosphates)

Pearls:

Intubated patients should not receive naloxone unless hemodynamically unstable.

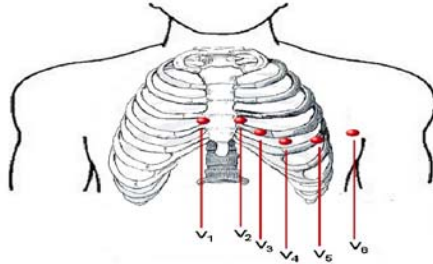
Tachycardia is not a contraindication to atropine administration.

Poison control should be consulted on all complex toxicology at 434-924-5543 or 1-800-451-1428.

Aeromedical resources will not transport contaminated patients.

Poisoning/ Overdose

B	Universal Care Protocol	B
B	Identify substance and assure decontamination.	B
B	Flush skin/membranes with water unless contraindicated.	B
EN	IV Procedure	EN
J	Naloxone 0.8 mg IV or IM for suspected narcotic overdose with respiratory depression.	J
EN	Diphenhydramine 1 mg/kg slow IVP for dystonic reaction (max dose of 50 mg).	EN
I/P	For Symptomatic Tricyclic Antidepressant Overdose: (if QRS >0.12 secs, hypotension, or dysrhythmia) •Sodium bicarbonate 1 mEq/kg slow IVP over 2 minutes	I/P
I/P	For Symptomatic Calcium Channel Blocker Overdose: (if bradycardic, QRS >0.12 secs, heart block, hypotension, lethargy, slurred speech, nausea, vomiting) •Calcium chloride 20 mg/kg slow IVP over 10 minutes •Sodium bicarbonate 1 mEq/kg slow IVP over 2 minutes.	I/P
I/P	For Symptomatic Organophosphate Poisoning: (secretions, bronchospasm, seizures, bradycardia) •Atropine 0.05 mg/kg IV doubled every 5-10 minutes until decreased secretions.	I/P
MC	Consider and treat for other types of overdoses or poisonings.	MC



*First intercostal space is below the clavicle at the sternal border.
The first palpable space at the sternal border is considered the
second intercostal space.*

- V1—4th intercostal space at the right sternal border**
- V2—4th intercostal space at the left sternal border**
- V3—Directly between V2 and V4**
- V4—5th intercostal space at midclavicular line**
- V5—5th intercostal space at anterior axillary line**
- V6—5th intercostal space at midaxillary line**



I Lateral	aVR	V1 Septal	V4 Anterior
II Inferior	aVL Lateral	V2 Septal	V5 Lateral
III Inferior	aVF Inferior	V3 Anterior	V6 Lateral

Location	STEMI	Reciprocal
Septal	V1, V2	None
Anterior	V3, V4	None
Anteroseptal	V1, V2, V3, V4	None
Lateral	I, aVL, V5, V6	II, III, aVF
Anterolateral	I, aVL, V3, V4, V5, V6	II, III, aVF
Inferior	II, III, aVF	I, aVL
Posterior	None	V1, V2, V3, V4

Cardiac Arrest: General Management

History <ul style="list-style-type: none"> •Events leading to arrest •Estimated down time •Past medical history •Medications •Terminal illness •Signs of rigor/lividity •DNR 	Physical <ul style="list-style-type: none"> •Unresponsive •Apneic •Pulseless 	Differential Diagnoses <ul style="list-style-type: none"> •Medical vs. trauma •V-fib/pulseless v-tach •Asystole •PEA
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B	Universal Care Protocol	B
B	Criteria for Death/ No Resuscitation?	B
B	CPR Interrupt compressions only as per AED prompt or every 2 minutes (5 cycles of CPR)	B
B	AED • If witnessed or bystander CPR in progress, apply immediately • If unwitnessed, use after 2 minutes of CPR	B
I/P	Assess Rhythm (do not use AED mode), Refer to appropriate protocol/algorithm	I/P
EN	IV or IO Procedure	EN
B	Advanced Airway Management Ventilate no more than 10/min (1 breath every 6-8 seconds)	B
I/P	Capnography Procedure if advanced airway is in place.	I/P

Pearls:

- Change compressors every 2 minutes.
- Allow full chest recoil.
- Check femoral/carotid pulse to verify effective CPR.

Asystole / Pulseless Electrical Activity

History: <ul style="list-style-type: none">•Past medical history•Medications•Events leading to arrest•End stage renal disease•Estimated down time•Suspected hypothermia•Suspected overdose•DNR	Physical: <ul style="list-style-type: none">•Pulseless•Apneic	Differential Diagnoses: <ul style="list-style-type: none">•Device error•Hypoxia•Hypothermia•Hydrogen ion (acidosis)•Hypo-/Hyperkalemia•Hypoglycemia•Hypovolemia•Trauma•Tension pneumothorax•Thrombosis coronary/pulmonary•Toxins•Tamponade
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Pearls:

Vasopressin should be administered only one time in place of either the first or second epinephrine dose.

General cardiac arrest and cpr protocols

Special resuscitation guidelines

BLS termination guidelines

Asystole / Pulseless Electrical Activity

B	General Cardiac Arrest protocol	B
I/P	Confirm asystole in more than one lead if applicable	I/P
I/P	Administer vasopressin 40 units (one time dose) Begin epinephrine after 3-5 minutes	I/P
I/P	Consider and treat for reversible causes as listed in differential diagnoses	I/P
I/P	Atropine 1 mg IV/IO every 3-5 minutes up to 3 doses if rate <60 bpm	I/P
I/P	1 mg epinephrine (1:10,000) IV/IO every 3-5 minutes up to 3 doses before considering termination of arrest.	I/P
MC	Contact Medical Command for special resuscitation situations	MC
MC	Termination of Care Policy	MC

Atrial Fibrillation/Flutter

History	Physical	Differential Diagnoses
<ul style="list-style-type: none"> •Medications <ul style="list-style-type: none"> Aminophylline, diet pills, thyroid supplements, decongestants, digoxin •Drugs <ul style="list-style-type: none"> nicotine caffeine •Past medical history •History of palpitations •Syncope/ near syncope •Use and compliance of anticoagulants 	<ul style="list-style-type: none"> •HR >150/min •QRS <0.12 secs •Rhythm is irregularly irregular •Dizziness, CP, SOB 	<ul style="list-style-type: none"> •Heart Disease (WPW) •Sick Sinus Syndrome •Myocardial infarction •Electrolyte imbalance •Exertion, pain, stress •Fever •Hypoxia •Hypovolemia or anemia •Drug effects •Hyperthyroidism •Pulmonary embolus

Pearls:

Energy settings for cardioversion should be per manufacturer recommendation.
 Pharmacological rate control is preferred over cardioversion unless the patient is unstable.
 Unstable is defined as BP less than 90 mmHg, altered mental status, or signs of decreased perfusion.

Adenosine is not effective in converting atrial fibrillation or flutter.

Document all rhythm changes with monitor strips.

Determine onset of symptoms (chronic vs. onset <48 hours).

Atrial fibrillation/flutter generally does not need to be treated for HR < 150.

Atrial Fibrillation/Flutter

B	Universal Care Protocol	B
EN	IV Procedure	EN
I/P	For a stable patient who is symptomatic with a ventricular rate 150 or greater, consider metoprolol (Lopressor) 5 mg IV. May be repeated every 10 minutes to a max of 15 mg to achieve ventricular rate of 120 or less.	I/P
I/P	For an unstable patient, synchronized cardioversion (total of 2 attempts).	I/P
I/P	For patients who do not respond to cardioversion or who have recurrent tachycardia, metoprolol (Lopressor) 5 mg IV prior to repeated cardioversion.	I/P
MC	Amiodarone 150 mg in 100 mL of D5W IV Piggyback over 10 minutes	MC
MC	Midazolam 2-5 mg IV if needed prior to synchronized cardioversion	MC

Bradycardia

History	Physical	Differential Diagnoses
<ul style="list-style-type: none">•Past medical history•Medications<ul style="list-style-type: none">Beta blockersCalcium channel blockersClonidineDigitalisACE Inhibitors•Pacemaker	<ul style="list-style-type: none">•HR < 60•Chest pain•Respiratory distress•Hypotension•Altered mental status•Syncope	<ul style="list-style-type: none">•Acute myocardial infarction•Hypoxia•Hypothermia•Athletes•Head injury (ICP)•Stroke•Spinal cord lesion•Sick sinus syndrome•AV blocks•Overdose

Pearls:

Unstable is defined as BP less than 90 mmHg, altered mental status, or signs of decreased perfusion.

TCP is the preferred treatment in 2nd degree, Type II and 3rd degree blocks.

Transplanted hearts will not respond to atropine.

Fluid therapy should be initiated as an adjunct to rate therapies. Administer fluid cautiously to patients with symptomatic bradycardia.

Bradycardia

B	Universal Care Protocol	B
EN	IV Procedure	EN
I/P	For a symptomatic patient, consider atropine 1mg repeated every 3-5 minutes as needed to a maximum of 3 mg.	I/P
I/P	For patients who have not responded to TCP and atropine, consider dopamine (Intropin) 5 to 20 mcg/kg/min to maintain BP of 90 mmHg.	I/P
MC	Consider Midazolam (Versed) 2-5 mg IV if needed during TCP when BP >90 mmHg.	MC

Chest Pain/ Acute Coronary Syndrome

History	Physical	Differential Diagnoses
<ul style="list-style-type: none"> •Age •Medications •Use of Viagra, Cialis, Levitra or herbal equivalents •Past medical history •Recent physical exertion •Onset •Palliation/Provocation •Quality •Radiation •Severity •Time 	<ul style="list-style-type: none"> •Chest Pain (pain, pressure, aching, tightness) •Location (substernal, epigastric, arm, jaw, neck, shoulder) •Pale, diaphoretic •Dyspnea •Nausea, vomiting •Anxiety 	<ul style="list-style-type: none"> •Trauma vs. medical •Angina vs. STEMI •Pericarditis •Pulmonary embolism •Asthma/ COPD •Pneumothorax •Aortic dissection or aneurysm •Reflux or hiatal hernia •Esophageal spasm •Pleuritic pain •Cocaine overdose

Pearls:

If use of Viagra or Levitra use within the past 24 hours or Cialis within 72 hours, contact medical command.

Inferior STEMI's are preload dependent and may not tolerate NTG or morphine well, use IV fluids as needed.

Use of nitropaste may be preferable to SL NTG if hypotension is likely to occur.

Diabetics, females, and geriatric patients often present with atypical chest pain or generalized complaints.

Can Zofran be changed to an enhanced level med?

Fix Metoprolol per George's paper....is it okay to list ST elevation in leads>>>?

Move 12 Lead protocol to "Procedures" Section

Asked....how should pts on daily Cialis be treated?

Chest Pain/ Acute Coronary Syndrome

B	Universal Care Protocol	B
B	Transmit 12 Lead ECG, Consult Medical Command for possible STEMI alert	B
B	Transport to cath lab facility for known or suspected MI.	B
B	Aspirin 325mg (4 baby aspirin) chewed.	B
EN	IV Procedure	EN
B	Nitroglycerin 0.4 mg every 5 minutes as needed. No maximum, keep BP >100 mmHg.	B
J	Apply 1 inch 2% Nitropaste (15 mg) topically keeping BP >100 mmHg.	J
I/P	For vomiting, consider ondansetron 4 mg IV repeated in 10 minutes if needed.	I/P
I/P	For persistent vomiting after two doses ondansetron, consider promethazine 12.5 mg IV. if > 65 years, reduce to promethazine 6.25 mg IV	I/P
I/P	Consider morphine sulfate 2 mg slow IV. May be repeated every 5-10 minutes to a max of 6mg keeping BP >100mmHg	I/P
I/P	Refer to hypotension and dysrhythmia protocols as indicated	I/P

Durable DNR

Emergency regulations governing the Durable Do Not Resuscitate (DDNR) program, adopted by the Virginia State Board of Health, became effective January 3, 2000. The emergency regulations amend the EMS Do Not Resuscitate (DNR) regulations and establish a DDNR order that follows the patient throughout the entire health care setting. Once issued by a physician for his patient, the DDNR Order applies wherever that patient may be – home, EMS vehicle, hospital, nursing home, adult care residence or other health care facility.

DDNR Orders can now be written for anyone, regardless of health condition or age. Inclusion of minors is a significant change in the emergency DDNR Order. Durable DNR Orders can be recognized by qualified EMS personnel at all times and in all settings. Valid EMS DNR Orders are considered Durable DNR Orders and do not expire on or after July 2, 1998. Qualified EMS personnel may honor written DNR Orders written for patient in a licensed health care facility.

The responding EMS provider should:

Perform routine patient assessment and resuscitation or intervention until it is confirmed that the patient has either a Virginia Durable DNR Order or the EMS DNR Order, issued on or after July 2, 1998.

Request the original Virginia Durable DNR Form or the EMS DNR Order or look for either form at patient's bedside, on the back of the patient's bedroom door, on the refrigerator or in the patient's wallet. If either of these forms has been defaced, consider the DNR Order to be invalid.

Make a good faith effort to verify identity of the patient through family, friends, and other health care personnel present or photo ID (such as a driver's license).

Be aware that a Virginia Durable DNR Form can be revoked by the following persons:

The patient, by destroying the Virginia Durable DNR Form or EMS DNR Form or by verbally withdrawing consent to the order.

The person authorized to consent on the patient's behalf.

A physician who is physically present at the patient's side.

Observe standard Durable DNR or EMS DNR orders:

These comforting interventions are encouraged:

Airway (excluding intubation or advanced airway management)
Suction

Durable DNR (continued)

These Resuscitative measures should be avoided:

Withhold or withdraw if resuscitation has begun prior to confirmation of Virginia Durable DNR status:

- Cardiopulmonary Resuscitation (CPR)
- Endotracheal intubation or other advanced airway management
- Artificial ventilation
- Defibrillation
- Cardiac resuscitation medications
- Continuation of related procedures, as prescribed by the patient's physician or medical protocols

Document the call:

Use the standard Pre-Hospital patient Care Report (PPCR) or agency run report to document which identification was used to confirm DNR status: Virginia Durable DNR Order Form, approved alternate form of identification, EMS DNR Order Form or other DNR form.

Indicate the Virginia Durable DNR Order Form number and the patient's attending physician's name.

Comfort the family if the patient has expired on arrival and follow agency's procedure for death at home.

Complete a PPCR or the agency run report.

Criteria for Death/ Withholding Resuscitation

DNR Patients

Indications:

- Pulseless, non-breathing patient who would normally require resuscitation AND
- Possess and on scene, properly completed, Virginia DDNR form

Procedure:

- Verify that the patient is the person named on the DDNR form.
- Cease all resuscitation efforts.
- Notify law enforcement
- Attach original DDNR to the completed PPCR.

Considerations:

- If the patient requires care and is NOT in cardiac arrest, provide care up to the limits of the DDNR and transport patient and DDNR form.
- Prehospital providers cannot honor other legal documents (living wills, etc) without contacting medical command.
- DDNR forms may be overridden by patient, guardian of patient, or on-scene physician

Deceased Patients

Indications:

- Rigor mortis and/or lividity
- Decapitation
- Traumatic cardiac arrest upon arrival

Procedure:

- Do not resuscitate any patient who meets the above criteria. If resuscitation efforts are in progress, consider consulting medical command for discontinuation of efforts (see Discontinuation Policy)
- Notify law enforcement

Emergency Custody Order

Order of substitute decision makers for incompetent patient: (Virginia Code § 54.1-2986)

- Legal guardian for patient (such as Medical Power of Attorney or agent for healthcare decisions in writing)
- Patient's spouse (except where divorce has been filed and is not final)
- Adult child of the patient
- Parent of the patient
- Adult brother or sister of the patient
- Other relative in descending order of blood relationship.

(Girlfriends, neighbors, others with no blood relationship DO NOT qualify as legal substitute decision makers).

Criteria for any ECO: a condition that is an immediate or imminent life threat with

•a patient who "because of mental illness . . . or any other mental disorder or physical disorder which precludes communication or impairs judgment, is incapable of making an informed decision about providing, withholding or withdrawing a specific medical treatment . . ."

1.Note religious caveat (i.e. Jehovah Witness) that "no person shall authorize treatment . . . that such person knows is contrary to the religious beliefs of the patient unable to make a decision, whether expressed orally or in writing."

2.Virginia Code § 16.1-336. Definitions:

3."Consent" means the voluntary, express, and informed agreement to treatment in a mental health facility by a minor fourteen years of age or older and by a parent or a legally authorized custodian.

4."Incapable of making an informed decision" means unable to understand the nature, extent, or probable consequences of a proposed treatment or unable to make a rational evaluation of the risks and benefits of the proposed treatment as compared with the risks and benefits of alternatives to the treatment. Persons with dysphasia or other communication disorders who are mentally competent and able to communicate shall not be considered incapable of giving informed consent.

Psych ECO (Virginia Code § 37.2-808).

Does NOT require a physician assessment to get from magistrate—family or witness to suicidal thoughts / actions / evidence of significant risk of self-harm can call magistrate and request.

"probable cause to believe that any person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment."

Emergency Custody Order

Medical ECO (Virginia Code § 37.1-134.21, § 37.2-1103). Emergency custody orders for adult persons who are incapable of making an informed decision as a result of physical injury or illness.

Requires:

Application by a licensed physician verifying that the "adult patient is incapable of making an informed decision as a result of physical injury or illness AND that the medical standard of care indicates that testing, observation, and treatment are necessary to prevent imminent and irreversible harm."

The physician's opinion of incapacity shall only be rendered after:

- either personal evaluation or electronic communication with EMS personnel on scene regarding their evaluation
- an attempt to communicate directly (or electronically) with the adult person to corroborate the EMS assessment of incapacity
- an attempt has been made to obtain consent from the adult person
- the adult person has failed to consent

The magistrate shall ascertain that the adult person:

- has no legally authorized person to give consent AND
 - is incapable of making an informed decision regarding necessary treatment AND
 - has refused transport AND
 - has indicated intention to resist transport AND
 - is unlikely to become capable of making an informed decision within the time required.
- Should the patient's condition change and the patient become capable of making an informed decision (i.e. hypoglycemia resolved), the physician must be contacted and the patient's wishes respected.

Information needed from you for magistrate to issue medical ECO ("adult person" = patient)

- Name and permanent address of "adult person" if known
- Name of law enforcement agency on scene (+ officer, badge # if possible)
- Name, hospital affiliation, and contact number of licensed physician requesting ECO
- Present location of "adult person"
- Name and address of hospital that "adult person" is to be transported to. (UVA Hospital, 1215 Lee Street, Charlottesville, VA 22908)