OVERDOSE (A51)
NOTE: DO NOT INDUCE VOMITING

	F	E	O	P	D
ASSESSMENT: look for serious signs and symptoms related to bradycardia or myocardial depression: systolic BP < 90, coronary type pain/discomfort, respiratory distress, pulmonary congestion, circulatory shock, CNS depression, ALOC. Critical patients are hypotensive and bradycardic.	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry < 94% or signs of hypoperfusion or respiratory distress.	X	X	X	X	
† ADVANCED AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA or ETI.					
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
***VASCULAR ACCESS:** IV/IO, rate as indicated.				X	
NASOGASTRIC TUBE: suction gastric contents only if patient is intubated and oral ingestion has occurred within 60 minutes.				X	
CONSIDER ACTIVATED CHARCOAL: 1 g/kg po if GCS is 15 or via NG tube if patient is intubated and oral ingestion has occurred within 60 minutes.				X	
TEST FOR GLUCOSE		X	X	X	
ORAL GLUCOSE: consider administering oral glucose to patients who are awake and have an intact gag reflex.	X	X	X	X	
D10: infuse 100 mL IV/IO if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post infusion. If blood glucose < 70 mg/dL infuse remaining 150 mL.				X	
BETA BLOCKERS					
ATROPINE: 0.5 mg increments slow IVP or 2 mg IM or 4 mg ET. Repeat every 3 - 5 minutes as needed. Maximum total dose of 3 mg.				X	
TRANSCUTANEOUS CARDIAC PACING: Place pacing pads on the Anterior/Posterior of thorax if possible. If patient remains hemodynamically unstable with serious signs & symptoms, DO NOT delay TCP waiting for vascular access or for atropine to take effect.				X	
PAIN MANAGEMENT: • **FENTANYL**: 1 – 2 mcg/kg IV/IO/IM/IN. If initial dose given IV/IO/IN, may repeat in 5 minutes, or if initial dose given IM may repeat in 10 minutes. Repeat doses at 0.5 mcg/kg. Maximum total 3 mcg/kg. • **MIDAZOLAM:** 0.5 – 1 mg increments IV/IO/IM/IN titrated to patient's pain or spasm up to 2 mg. Hold for SBP < 100.				X	
CALCIUM CHANNEL BLOCKER					
CALCIUM CHLORIDE: 100 mg IV push over 2 minutes if systolic BP < 90 and HR < 60. Repeat doses of 100 - 200 mg IV over 2 - 4 minutes, if hypotension and bradycardia persist.				X	
ATROPINE: 0.5 mg increments slow IVP or 2 mg IM or 4 mg ET. Repeat every 3 - 5 minutes as needed. Maximum total dose of 3 mg.				X	
TRICYCLIC ANTIDEPRESSANTS					
SODIUM BICARBONATE • 1 mEq/kg slow IV push for cardiac dysrhythmia or QRS complex wider than 0.10 second. Repeat as indicated until QRS ≤ 0.10 seconds. **OR** • Infusion**:** Mix 100 mEq in1000 mL NS. Start at 150 gtt/min (mL/hr), titrate up for cardiac dysrhythmia or QRS complex wider than 0.10 sec.				X	

TRICYCLIC ANTIDEPRESSANTS CONT.	F	E	O	P	D
****MIDAZOLAM FOR SEIZURE:** Do not delay for IV/IO access. Closely monitor respirations/airway and support ventilation as indicated. • IM – 10 mg. May repeat x 1 if seizure continues > 5 minutes. • IN – 10 mg. May repeat x 1 if seizure continues > 5 minutes. • IV/IO - 1-2 mg every 2 minutes until seizure stops or max 10 mg.				X	
OPIOID					
VENTILATE: With oxygen and BVM if hypoventilation, goal ≥ 94%.	X	X	X	X	
NALOXONE: one spray pre-packaged IN (typically 2 – 4 mg) for respiratory depression. If opioid overdose is suspected, may repeat every 2-3 minutes in alternating nostrils, to a total of 12 mg. Consider alternate cause of obtundation/respiratory depression if ineffective.		X	X	X	
NALOXONE: 0.4 - 2 mg IV/IO//IM; may repeat to a total of 12 mg. If opioid overdose is suspected, may repeat every 2-3 minutes in alternating nostrils, to a total of 12 mg.				X	
ALL HYPOTENSION					
PUSH DOSE EPINEPHRINE: for hypotension – titrate to SBP ≥ 90 • Mix 1 mL of Epi 1:10,000 (0.1 mg/mL) with 9 mL of NS = concentration of 1:100,000 (0.01 mg/mL) • Label syringe "epinephrine 10 mcg/mL" • 0.5 – 1 mL (5 – 10 mcg) IVP every 1 – 5 minutes If SBP does not stabilize ≥ 90 after two doses, consider epinephrine drip. Refer to Epinephrine Drip Chart (TCEMSA Rx Guidelines)				X	

***Administer fluid boluses with caution due to the high incidence of pulmonary edema in tricyclic overdose patients.**

****Most tricyclic overdose seizures are short in duration and do not require midazolam.**

† Maximize naloxone doses prior to attempting advanced airway placement, if narcotic overdose is suspected.