CNS ILLNESS PROTOCOL

Number: II.C.7.
Date: 7/22/98

Purpose: **To provide a process for the assessment and management of the patient experiencing altered CNS symptoms. This protocol may be used in conjunction with the Altered Mental Status protocol.**

I. Assessment Information

MB S P

A. History:
   1. Past Medical History: seizures, diabetes, cardiovascular disease, medications
   2. Current History: possible head or spinal trauma, onset and presentation of symptoms (ie: headache, seizure, altered LOC, focal deficit).

B. Specific Objective Findings:
   1. Level of consciousness, vital signs, pupils, temperature
   2. Motor function, sensation
   3. Medic Alert tags
   4. If signs of trauma, refer to the Trauma Protocol

II. Management

A. Utilize universal precautions.

B. Evaluate and maintain airway, provide for oxygenation and support ventilation as needed.

C. Assess adequacy of perfusion:
   1. Monitor and document level of consciousness
   2. Maintain patient in horizontal position (unless respiratory distress present, then elevate torso as needed).
   3. Monitor vital signs frequently.

D. Transport

S P E. Obtain vascular access.

M B S P F. If cause of neurologic deficit is unknown, refer to Altered Mental Status Protocol.

P G. Monitor EKG.

H. If patient symptoms have onset less than 6 hours, complete the Thrombolytic Checklist and provide to ED staff along with EMS Medical Record.

CONTACT MEDICAL CONTROL

M B S P **III. Special Considerations**

A. Consider all causes of neurologic deficit, such as: hypoxia, trauma, CVA, hypoglycemia, hypothermia, hypotension, sepsis, drug intoxication, seizure.

B. The value of a reliable history cannot be overlooked.

NOTE: If potential CVA symptoms have been present for less than 6 hours, expedite transport to hospital.