

**I. General Considerations**

- A. The causes of weakness are many; easily treated causes must be readily sought and corrected.
  - B. The patient's level of consciousness, combined with an assessment of the patient's perfusion (pulse, blood pressure, skin condition), indicates the urgency of the transport.
  - C. Patients who cannot meet life's daily needs (get up to wash, eat, eliminate) and have no assistance at home should be taken to the hospital by ambulance.
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**II. History**

Perform a focused history and physical exam with particular attention to:

- A. When was the patient last completely well?
  - B. Determine the onset, progression and duration of symptoms.
  - C. Obtain a past medical history including alcohol use, diabetes, epilepsy, hypertension, cardiac disease, lung disease, stroke, cancer.
  - D. What medications has the patient been or is the patient supposed to be taking (including over the counter medication)?
  - E. Is there a history of injury or insult (trauma, inhalation, choking, aspiration, etc.)?
  - F. Has there been any: fever, cough, rash, urinary burning or frequent urination, yellowing of the skin, seizures, headaches, nausea, vomiting, diarrhea, trouble breathing?
  - G. Has there been any blood noted in stools or have they been black?
  - H. Has the patient been urinating?
  - I. Has the weakness affected only part of the body? Which part?
  - J. Does the patient have or has the patient had any pain anywhere?
  - K. Has the patient been eating?
  - L. Is anyone else at home ill?
  - M. Does light bother the patient's eyes?
  - N. Is the patient's neck stiff?
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**III. Physical Examination**

- A. Perform an initial assessment with special attention to the adequacy of ventilation.
- B. Perform a focused history and physical exam.
- C. Assess the breath sounds if you are trained to do so.
  - 1. Are they present and equal right and left?
  - 2. Are there rales, rhonchi (crackles), or wheezes?
- D. Assess the skin.
  - 1. Is it warm, hot or cold?
  - 2. Is it dry or moist?
  - 3. Note any color changes (e.g., pale, cyanotic, red).
  - 4. Is there bruising or evidence of injury?
- E. Assess the patient for signs of peripheral edema.
  - 1. Are the ankles swollen?
  - 2. Is there edema over the lower back and sacrum area?
- F. Assess the level of consciousness.
- G. Assess the patient's neurological condition.
  - 1. Check pupils for size, symmetry, reactivity.
  - 2. Assess motor function. Is the patient moving all four extremities? Is there equal grip strength? Is there posturing?
  - 3. Is sensation to touch intact in all four extremities?
- H. Is there an unusual breath odor (alcohol, fruity/acetone)?
- I. Inspect the surroundings.
  - 1. Check for pill bottles, syringes, etc. (bring with the patient).

2. Note odor in the house, unvented heaters, etc.
  - J. Assess the cardiac rhythm if trained to do so.
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**IV. Treatment**

{If other conditions are present, follow the appropriate protocol(s).}

**Basic**

- A. Establish an airway, maintain as indicated, suction as needed.
- B. Administer high concentration oxygen.
- C. Transport the patient in a position of comfort.

**Intermediate**

- D. Secure IV access. Obtain blood specimen for glucose determination at the hospital if the receiving hospital desires it.
- E. Perform capillary blood glucose determination.
- F. *If patient's blood glucose level is <80 mg/dl, administer dextrose 50% 25 gm IV in a secure vein for an adult (standing order for paramedics) or 0.5 - 1 gm/kg for a child.*
- G. ▲ *Administer thiamine 100 mg IV if dextrose is to be administered.*
- H. ▲ *If IV access cannot be secured, administer 1 mg glucagon IM*

**Paramedic**

- I. Monitor the cardiac rhythm and treat per applicable arrhythmia/dysrhythmia protocol. *If authorized by medical direction, obtain a 12-lead EKG.*