7. Place cardiac monitor and examine rhythm strip for arrhythmia potentials (consider 12-lead EKG)
8. Check blood glucose Level
9. Monitor pulse oximetry and $EtCO_2$ for respiratory decompensation
10. Perform carboxyhemoglobin and cyanide device assessment, if available
11. Identify specific suspected agent if possible
12. Pertinent cardiovascular history or other prescribed medications for underlying disease
13. Patient pertinent history
14. Patient physical examination

Treatment and Interventions

1. Assure a patent airway
2. Administer (humidified if available) oxygen and if hypoventilation, toxic inhalation, or desaturation noted, support breathing
    a. Maintain the airway and assess for airway burns, stridor, or airway edema and if indicated, perform intubation early (recommendation to avoid supraglottic airways — cricothyrotomy may be required in rare severe cases
    b. Non-invasive ventilation techniques
        i. Use continuous CPAP, BiPAP, intermittent positive pressure breathing (IPPB), HFNC, and/or bilevel nasal CPAP for severe respiratory distress or impending respiratory failure
        ii. Use bag-valve-mask (BVM) ventilation in the setting of hypoventilation, respiratory failure, or arrest
3. While albuterol 2.5 mg nebulized is usually sufficient for mild wheezing without clinical distress, albuterol 5 mg nebulized (or 6 puffs metered dose inhaler) should be administered to all patients in respiratory distress with signs of bronchospasm either by basic life support BLS or ALS clinicians. This medication should be repeated at this dose with unlimited frequency for ongoing distress
4. Ipratropium 0.5 mg nebulized should be given up to 3 doses, in conjunction with albuterol
5. Initiate IV access for infusion of lactated Ringer's or normal saline and obtain blood samples in effort to record pre-treatment levels, e.g., via point-of-care testing, associated with EMS management (e.g., glucose, lactate, cyanide)
6. Fluid bolus (20 mL/kg) if evidence of hypoperfusion
7. If the patient is experiencing significant pain, administer IV/IO analgesics
    a. Morphine sulfate 0.1 mg/kg IV or IO
    b. Fentanyl 1 mcg/kg IV or IO
8. Eye irrigation early
9. Treat topical chemical burns [See appropriate Toxins and Environmental Section guideline(s)]
10. In severe respiratory irritation, in particular hydrogen sulfide, with altered mental status and no improvement with removal from the toxic environment, administer oxygen (humidified if available) as appropriate with a target of achieving 94–98% saturation. Consider consultation for transfer to a tertiary care hospital. If carbon monoxide is a confirmed or suspected element of the inhalant, a facility with hyperbaric oxygen capabilities is preferred