3. **Co-morbidities**: reduced medication dosages may apply to patients with renal disease (i.e., on dialysis or a diagnosis of chronic renal insufficiency) or hepatic disease (i.e., severe cirrhosis or end-stage liver disease)
4. **Vital Signs**:
    a. Oxygen
        i. Administer oxygen as appropriate with a target of achieving 94–98% saturation
        ii. Supplemental oxygen administration is warranted to patients with oxygen saturations below this level and titrated based upon clinical condition, clinical response, and geographic location and altitude
        iii. The method of oxygen delivery should minimize or treat hypercarbia associated with hypoventilation (e.g., non-invasive positive airway pressure devices)
    b. Normal vital signs (See Table 1. Normal Vital Signs)
        i. Hypotension is considered a systolic blood pressure less than the lower limit on the chart
        ii. Tachycardia is considered a pulse above the upper limit on the chart
        iii. Bradycardia is considered a pulse below the lower limit on the chart
        iv. Tachypnea is considered a respiratory rate above the upper limit on the chart
        v. Bradypnea is considered a respiratory rate below the lower limit on the chart
    c. Hypertension. Although abnormal, may be an expected finding in many patients
        i. Unless an intervention is specifically suggested based on the patient's complaint or presentation, the hypertension should be documented, but otherwise, no intervention should be taken acutely to normalize the blood pressure
        ii. The occurrence of symptoms (e.g., chest pain, dyspnea, vision change, headache, focal weakness or change in sensation, altered mental status) in patients with hypertension should be considered concerning, and care should be provided appropriate with the patient's complaint or presentation
5. **Secondary Survey**: if patient has critical primary survey problems, it may not be possible to complete
6. **Critical Patients**: proactive patient management should occur simultaneously with assessment
    a. Ideally, one clinician should be assigned to exclusively monitor and facilitate patient-focused care
    b. Other than lifesaving interventions that prevent deterioration en route, treatment and Interventions should be initiated as soon as practical, but should not impede extrication or delay transport to definitive care
7. **Air Medical Transport**: air transport of trauma patients should generally be reserved for higher acuity trauma patients where there is a significant time saved over ground transport, where the appropriate destination is not accessible by ground due to systemic or logistical issues, and for patients who meet the American College of Surgeons Committee on Trauma (ACS-COT) *2022 National Guideline for the Field Triage of Injured Patients* anatomic, physiologic, and situational high-acuity triage criteria. In selected circumstances, air medical resources may be helpful for non-trauma care (e.g., stroke, STEMI when geographically constrained)
8. **Additional Protective Measures for the EMS Clinician:** Due to suspected or confirmed hazards and/or highly infectious contagious diseases, traditional patient treatment and care delivery may be altered due to recommendations by federal, state, local or jurisdictional officials