General:

- This procedure is primarily for use by Paramedic providers authorized at the PI and PII level. Those authorized at PIII, or above, are not required to perform consults, with the exception of Termination of Resuscitation.
- Consults will be approved/denied by a PIV in person or via radio. PIII are able to approve/deny a consult only if they are on-scene with the patient.
- MCHD permits certain operational, and online medical authorization to PI and PII providers on a case-by-case basis. The Consult procedure is the method by which this authorization is sought and granted.
- Refer to CG-07 for guidelines for performing a Consult.

Equipment:

- All consults should be conducted via Radio unless impractical to do so. The only acceptable alternative is to call Alarm on the phone and ask to be connected to a District Chief on a recorded line for a Consult.

Procedure:

There are five categories of situations for which a Consult is needed:

- Guidance
  - A provider may request a consult at any time to discuss thought processes, treatment plan, or for any operational concern.
- Delayed Sequence Intubation (DSI)
  - A provider may begin the DSI procedure prior to consult, however must consult prior to administering the inductive dose of Ketamine (or prior to administration of a paralytic if patient did not require a sedative).
  - In instances where the patient was intubated (SGA or ETT) without sedative/paralytic, such as cardiac arrest, the provider may administer a sedative/paralytic following the procedure if indicated. This is not considered to be DSI.
  - If a DSI consult is approved, it can be expected that the provider is approved for Ketamine/Rocuronium to facilitate intubation, and subsequent Ketamine for continued sedation. If post-intubation paralysis is desired it must be approved specifically.
  - It is understood that if the provider is unable to ventilate and unable to oxygenate for whatever reason during the procedure that the provider must perform a surgical airway. In these ultra-rare occurrences, an additional consult is not required.
  - Following successful intubation, or the placement of an SGA, the provider should provide a patient report, with full vitals including capnography, to the approving District Chief via radio.
- High Risk Refusal
  - The intent of consulting for a High-Risk Refusal is not for guidance per se, but rather ensuring that MCHD is mitigating any unnecessary liability. If a provider's clinical judgement is that the refusing patient has an unreasonably high risk of worsening outcome/death by not consenting to transport, a High-Risk Refusal consult should be performed.
- Termination of Resuscitation
  - PI, PII, PIII and PIV must consult with the on-call Medical Director prior to termination of medical or traumatic resuscitation efforts.
  - The highest ranking provider on-scene is required to call ALARM and ask to be connected with the on-call Medical Director.

- Any treatment outside the limits of the SDO manual
    - The Standard Delegated Orders were written for the most common scenarios that a provider will experience. If the patient requires a procedure not listed in the SDO's, or medication doses outside the ranges listed, a consult must be performed.

Considerations:

- While many patient situations require decisive action by the provider, there are rarely any conditions that cannot be managed by BLS or basic ALS care while the provider performs a Consult for the above-listed authorization.
- Any time a PI or PII provider performs an above-listed intervention without obtaining prior authorization via Consult the provider should notify the Assistant Chief – Clinical as soon as possible.