GENERAL CARE FOR THE POISONED/OVERDOSED PATIENT		
ICP	Take care not to become contaminated, and consider the possibility of other affected workers, occupants or first-aiders (if applicable). Remove the patient from the dangerous area if safe to do so.	**AP**
ICP	Airway / ventilatory support as necessary	**AP**
ICP	Specific antidotes and treatment as appropriate (see below)	**AP**
ICP	Consider the need for Emergency Apprehension (and Statement of Action Taken)	**AP**
ICP	Monitor ECG and treat arrhythmias (as per CMG 6, 7, 8)	**AP**
ICP	IV fluid as per CMG 14	**AP**
ICP	Consider adrenaline infusion for patients who are profoundly hypotensive and have not responded to fluid replacement	
ICP	Consider contacting Poisons Information (call 13-11-26) for specifics of particular poison/medication, if appropriate	**AP**
ICP	Symptomatic management as per appropriate CMGs e.g. temperature abnormalities (CMG 11), suspected ACS (CMG 16), seizures (CMG 22), hyperkalaemia (CMG 27), etc.	**AP**
ICP	Consider prolonging resuscitative efforts in these patients	**AP**
ICP	Do not delay on scene – some poisons/medications are time critical for treatment to be effective	**AP**

TRICYCLIC ANTIDEPRESSANTS		
ICP	Treat wide QRS, seizure activity and/or cardiac arrest secondary to tricyclic overdose, with sodium bicarbonate	
ICP	Decreased LOC – consider hyperventilation if ventilated	**AP**
ICP	Consider monitoring $EtCO_2$ – aim for <35mmHg	**AP**

continues over

ORGANOPHOSPHATES		
ICP	Where feasible – remove contaminated clothing, wash skin with soap and water	AP
	While ever cholinergic effects are present (salivation, bronchospasm, excess respiratory secretions, sweating, nausea, vomiting, hypotension, bradycardia, pin point pupils):	
ICP	administer IM atropine (no upper limit on doses) or	AP
ICP	administer IV atropine – doubling each repeat dose (e.g. 0.6mg → 1.2mg → 2.4mg → 4.8mg) (no upper limit on doses)	
ICP	Ensure hospital is notified of contaminated patient	AP

SUSPECTED ALCOHOL INTOXICATION		
ICP	Consider other causes of altered LOC (i.e. AEIOUTIPS – see CMG 15) even if there is a history of alcohol consumption. Thoroughly assess patient and document all findings.	AP
ICP	Consider appropriate ongoing management of patient: e.g. hospital, sobering up shelter, at home in the care of a non-intoxicated adult	AP

CARBON MONOXIDE / SMOKE INHALATION		
ICP	Beware of hazards – self-asphyxiation and/or explosion. Remove patient from danger	AP
ICP	Treat according to respiratory distress or upper airway obstruction guideline	AP
ICP	100% oxygen with PEEP if carbon monoxide is suspected	AP
ICP	Any person who has suffered an inhalation injury of toxic substances is to be transported to hospital (pulmonary oedema may be a late complication)	AP
ICP	Urgently transport if there is a decreased level of consciousness	AP

OPIOIDS		
ICP	IM naloxone	AP
ICP	Follow with IV naloxone	
ICP	With long-acting or synthetic opioids, regardless of initial response to naloxone, strongly encourage transport or close monitoring	AP