REGIONAL EMERGENCY MEDICAL ADVISORY COMMITTEE

NEW YORK CITY

PREHOSPITAL TREATMENT PROTOCOLS

APPENDICES

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PROTOCOL APPENDICES

APPENDIX A
TELEPHONE DIRECTORY AND REFERRALS

EMS OFFICES	
Regional EMS Council of NYC	(212) 870-2301
Regional Emergency Medical Advisory Committee (REMAC) of NYC	(212) 870-2301
NYS Dept. of Health (Central Office)	(518) 402-0996
NYS Dept. of Health – NYC Field Office	(212) 417-4455

FDNY BUREAU OF EMERGENCY MEDICAL SERVICES	
Telemetry	(718) 899-5062
Toll Free	(800) 281-TELM (8356)
EMS Operations	(718) 999-2770
Division of Training	(718) 281-8325
REMAC Testing	(718) 999-2671
EMD POSITIONS	
ADMINISTRATION 1	(347) 250-6363
ADMINISTRATION 2	(347) 250-6364
ADMINISTRATION 3	(347) 250-6365
ADMINISTRATION FAX	(347) 250-6091
ARD SUPERVISOR (RM 306)	(347) 253-6422
ARD SUPERVISOR (RM 310)	(347) 250-6423
BRONX ASSIST	(347) 250-6352
BRONX NORTH	(347) 250-6353
BRONX SOUTH	(347) 250-6351
BROOKLYN ASSIST 1	(347) 250-6344
BROOKLYN ASSIST 2	(347) 250-6346
BROOKLYN CENTRAL	(347) 250-6345
BROOKLYN NORTH	(347) 250-6347
BROOKLYN SOUTH/S.I.	(347) 250-6343
CBEMS	(347) 250-6329
CITYWIDE 1	(347) 250-6334
CITYWIDE 1 ASSIST	(347) 250-6335
CITYWIDE 2	(347) 250-6337
CITYWIDE 2 ASSIST	(347) 250-6336
COMMANDING OFFICER	(347) 250-6361
DEPUTY CHIEF	(347) 250-6360
DISPATCH COMMANDER	(347) 250-6362
DISPATCH COMMANDER FAX	(347) 250-6090
DIVERSIONS DESK	(347) 250-6332

DIVERSIONS DESK FAX	(347) 250-6083
FIRE DESK	(347) 250-6330
INQUIRY/TRACKING DESK	(347) 250-6331
INQUIRY/TRACKING DESK FAX	(347) 250-6082
MANHATTAN ASSIST 1	(347) 250-6339
MANHATTAN ASSIST 2	(347) 250-6341
MANHATTAN CENTRAL	(347) 250-6340
MANHATTAN NORTH	(347) 250-6342
MANHATTAN SOUTH	(347) 250-6338
QUEENS ASSIST	(347) 250-6349
QUEENS EAST	(347) 250-6350
QUEENS WEST	(347) 250-6348
RELAY DESK	(347) 250-6333
SUPERVISOR BK/SI	(347) 250-6324
SUPERVISOR BX	(347) 250-6325
SUPERVISOR MN	(347) 250-6326
SUPERVISOR QN	(347) 250-6327

ABUSE/DOMESTIC VIOLENCE	
NYS Child Abuse/Maltreatment Register (Mandated Reporter Express Line)	**(800) 635-1522**
NYS 24 Hour Child Abuse Hot-Line	(800) 342-3720
Domestic Violence 24 Hour HOT-LINE	(800) 621-4673 (HOPE)

CRIME VICTIMS	
Crime Victims 24 Hour Hot-Line	(212) 577-7777
State Crime Victims Compensation Board	(212) 417-5160
Sex Crimes Report Line (NYCPD)	(212) 267-7273

AGING	
NYC Department for the Aging Central Information and Referral	(212) 442-1000
Social Security (MEDICARE)	(800) 772-1213
Alzheimer's Resource Center	(212) 442- 3086

CPR TRAINING	
Regional EMS Council of NYC	(212) 870-2301
New York Heart Association	(212) 661-5335
American Red Cross	(212) 787-1000

PROTOCOL APPENDICES

APPENDIX A (continued)

TELEPHONE DIRECTORY AND REFERRALS

SOCIAL SERVICES	
Human Resources Administration General Information	(877) 474-8411
Utility Cut-Off Emergencies (Public Service Assistance)	(800) 342-3355
Legal Services (Legal Aid Society)	(212) 577-3300

OTHER SERVICES	
ASPCA (Injured Animals)	(718) 649-8600
Transportation (NYC Transit Authority)	(718) 330-1234
Gas Leaks	(718) 643-4050
POISON Control	(212) POISONS (764-7667)

PROTOCOL APPENDICES

APPENDIX B
PATIENT ASSESSMENT

ADULT PRIMARY SURVEY

	Assessment	Management
Scene size-up	▪ Body Substance Isolation ▪ Scene safety ▪ Mechanism of Injury/Nature of Illness ▪ Consider C-spine	▪ Goggles, gloves, gown, mask – as needed ▪ Ensure safety of **self** & **partner**, patient & bystanders
Initial	▪ General impression of the patient ▪ Level of Consciousness ▪ Chief complaint	▪ **A-**Alert ▪ **V**-Responds to Verbal stimuli ▪ **P**-Responds to Painful stimuli ▪ **U**-Unresponsive – no gag or cough
Airway and Breathing	▪ Manage airway ▪ O2, as needed ▪ Ensure adequate ventilation ▪ Treat any life threatening airway or breathing problems	▪ Modified Jaw Thrust ▪ Suction, as needed ▪ OPA/NPA, as needed ▪ CPR, as needed
Circulation	▪ Skin color ▪ Assess for pulses (BP estimation) *-Radial = 80+* *-Femoral = 70+* *-Carotid = 60+* ▪ Major Bleeding	▪ Control any obvious bleeding ▪ Elevation of legs, as needed ▪ Support circulation
Transport Decision	▪ Identify urgency of transport	▪ Immediate or continued assessment

APPENDIX B (continued)
PATIENT ASSESSMENT

PEDIATRIC PRIMARY SURVEY

	Assessment	Management
Scene size-up	▪ Body Substance Isolation ▪ Scene safety ▪ Mechanism of Injury/Nature of Illness ▪ Consider C-spine	▪ Goggles, gloves, gown, mask – as needed ▪ Ensure safety of **self** & **partner**, patient & bystanders
Initial	▪ General impression of the patient ▪ Level of Consciousness ▪ Chief complaint	▪ **A-**Alert ▪ **V**-Responds to Verbal stimuli ▪ **P**-Responds to Painful stimuli ▪ **U**-Unresponsive – no gag or cough
Airway and Breathing	▪ Manage airway ▪ O2, as needed ▪ Ensure adequate ventilation ▪ Treat any life threatening airway or breathing problems	▪ Modified Jaw Thrust ▪ Suction, as needed ▪ OPA/NPA, as needed ▪ CPR, as needed
Circulation	▪ Skin color ▪ Assess for pulses (BP estimation) ▪ Major Bleeding	▪ Control any obvious bleeding ▪ Elevation of legs, as needed ▪ Support circulation
Transport Decision	▪ Identify urgency of transport	▪ Immediate or continued assessment

Assess respiratory effort
- ⇒ **Use of accessory muscles**
- ⇒ **Sternal retractions**
- ⇒ **Stridor/grunting**
- ⇒ **Posturing**

Normal BP estimate: 90+ (2 x child's age)

APPENDIX C
DO NOT RESUSCITATE ORDER / MOLST

The following is the NYS DOH BEMS Policy Statement

DNR and Medical Orders for Life- Sustaining Treatment (MOLST)

Bureau of EMS Policy Statement	
Policy Statement #	11-02
Date	March 1, 2011
Subject	Re: DNR and Medical Orders for Life- Sustaining Treatment (MOLST)
Supercedes/Updates	99-10, 08-07, 10-05

Purpose

This policy updates all EMS providers and agencies of changes in the laws regarding Do Not Resuscitate (DNR) orders and Medical Orders for Life-Sustaining Treatment (MOLST). The Department now has an approved MOLST form, DOH-5003 Medical Orders for Life-Sustaining Treatment. This form does not replace the Non-hospital Order Not to Resuscitate in either the English or the Spanish version (DOH-3474, DOH-3474es), but rather provides an alternative. Nonhospital DNR orders are now governed by Public Health Law Article 29 CCC.

Additionally, this policy will provide an introduction to the Family Health Care Decisions Act (FHCDA). FHCDA allows family members or certain other individuals to make health care decisions, including decisions about the withholding or withdrawing of life-sustaining treatment, on behalf of patients who lose their ability to make such decisions and have not prepared advance directives regarding their wishes. **FHCDA went into effect on June 1, 2010.**

Nonhospital Order Not to Resuscitate

The New York State Department of Health has an approved standard Out of Hospital DNR form (DOH-3474) that is legally recognized statewide for DNR requests occurring outside of Article 28 licensed facilities. This form is intended for patients not originating from a hospital or nursing home.

For patients with a valid Nonhospital DNR or MOLST form with a DNR order, the Public Health Law allows a standard metal bracelet to be worn by the patient, which includes a caduceus and the words "DO NOT Resuscitate." EMS providers should assume that there is a valid DNR in place when a DNR bracelet is identified on a patient.

Medical Orders for Life-Sustaining Treatment (MOLST)

MOLST is an alternative form for patients to document their end-of-life care preferences and to assure that those preferences are made known to health care providers across the health care delivery system. Unlike the Nonhospital Order Not to Resuscitate, the MOLST form documents DNI orders and orders regarding other life-sustaining treatment, in addition to DNR orders. MOLST should be honored by EMS agencies, hospitals, nursing homes, adult homes, hospices and other health care facilities and their health care provider staff. MOLST has been approved by the Office of Mental Health and the Office for People With Developmental Disabilities for use as a nonhospital DNR/DNI form for persons with developmental disabilities, or persons with mental illness, who are incapable of making their own health care decisions or who have a guardian of the person appointed pursuant to Article 81 of the Mental Hygiene Law or Article 17-A of the Surrogate's Court Procedure Act.

Chapter 197 of the Laws of 2008 authorized the MOLST form to be used statewide as an alternative form for nonhospital DNR and/or DNI and allowed EMS providers to honor this form in all counties in New York State.

Both the Nonhospital Order Not to Resuscitate form (DOH-3474) and the MOLST form (DOH-5003) are New York State Department of Health forms. The MOLST form was updated in June 2010 to make it more user-friendly and to align the form with the recently enacted Family Health Care Decisions Act. The MOLST form is currently utilized by many health care systems. **If a patient has a prior version of the MOLST in place and signed by a physician, the form is still considered VALID, and the patient care orders should be honored, unless it is known that the patient's form has been revoked.**

What are the DNR/DNI rules that affect EMS agencies and providers now?

1. Effective July 7, 2008, the MOLST form is approved for use statewide without the need for a standard one-page Nonhospital Order Not to Resuscitate form.
2. EMS agencies must still honor the standard one-page nonhospital DNR form or bracelet.
3. When a patient wears a DNR bracelet, it refers ONLY to the do not resuscitate rules that apply to the nonhospital DNR order. At present there are no nonhospital DNI bracelets.
4. The MOLST form also provides the patient and his/her physician with the ability to give a Do Not Intubate (DNI) order to health care providers including EMS. Refer to Section E on the MOLST form to review DNI information.
5. Occasionally EMS providers may encounter a patient who has a newly completed MOLST that does not have the authorizing physician's signature. While the unsigned MOLST form may provide the EMS provider with information about the patient's treatment preferences, it is not a valid DNR or other order. In the case of an unsigned MOLST form EMS providers should:
    1. Initiate resuscitation following applicable state and/or regional protocols;
    2. Obtain clinical information on status of the patient;
    3. Confirm the MOLST form is specific to the patient;
    4. Consult with local medical control and relay the above information; and
    5. Follow the direction of the medical control physician.

What are the differences and similarities between the standard one-page nonhospital DNR order and the MOLST form?

1. The MOLST form (DOH-5003) is a bright pink multi-page form; however, a photocopy or facsimile of the original form is acceptable and legal. A Nonhospital Order Not to Resuscitate form (DOH-3474) is a single-page form on white paper with black ink.
2. The MOLST form is meant to be utilized by health care providers across the health care system. It is not limited to EMS agencies; it travels with the patient to different care settings. The Nonhospital Order Not to Resuscitate form is not intended for use in facilities.
3. MOLST provides for end-of-life orders concerning resuscitation and intubation for Advanced EMTs when the patient is in full cardio-pulmonary arrest or has progressive or impending pulmonary failure without acute cardiopulmonary arrest. The Nonhospital Order Not to Resuscitate form (DOH-3474) only applies to patients in full cardio or pulmonary arrest.
4. Both forms, the MOLST form and the Nonhospital Order Not to Resuscitate form (DOH-3474), must be authorized by a physician.
5. Unlike the Nonhospital Order Not to Resuscitate form, there are multiple patient orders contained on the MOLST form that are intended for other health care providers to follow in other health care settings such as the hospital or nursing home.

6. The MOLST form gives prehospital care providers and agencies direction regarding the patient's end-of-life treatment orders in Section A (page 1) and Section E (page 2). See below.

Orientation to the MOLST Form, DOH-5003 (June 2010)

Section A - Resuscitation Instructions When Patient has No Pulse and/or is Not Breathing

Section A is titled Resuscitation Instructions When a Patient Has No Pulse and/or Is Not Breathing. It provides two boxes, only one of which will be checked. The first box, "CPR Order: Attempt Cardio-Pulmonary Resus-citation," indicates that the patient wants all resuscitation efforts to be made, including defibrillation and intuba-tion, if they are found in cardiac and/or respiratory arrest.

The second box, "DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)," indicates the patient does not want any resuscitation efforts made, and the patient wishes to be allowed a natural death. This does not prevent treatment up to the point of resuscitation.

Section B - Consent for Resuscitation Instructions

This section MUST be filled out in accordance with New York State law. A box should always be checked to in-dicate who consented to the decision, and the name of the decision-maker should be printed. If the signature line is left blank, the box for verbal consent should be checked. If the box for verbal consent is checked, the at-tending physician who signed the order should have witnessed the consent or two other adult witnesses should be indicated.

Section C - Physician Signature for Sections A and B and for section E

A licensed physician must always sign the orders. If the physician is licensed in a border state, the physician must insert the abbreviation for the state in which he/she is licensed, along with the license number.

As with the Nonhospital Order Not to Resuscitate form (DOH 3474), the MOLST form is required to be reviewed by the physician periodically. However, both forms should be considered valid unless it is known that the medical order has been revoked.

Section D - Advance Directives

This section contains multiple check boxes listing advanced directives for the patient.

Section E - Orders for Other Life-Sustaining Treatment and Future Hospitalization When the Patient has a Pulse and the Patient is Still Breathing

This section contains several parts containing treatment options that must be reviewed by prehospital care providers and includes:

Treatment Guidelines

- Comfort measures only
- Limited medical interventions
- No limitations

Instructions for Intubation and Mechanical Ventilation

- Do Not Intubate (DNI)
- A trial period

  - Intubation and mechanical ventilation
  - Non-invasive ventilation (e.g. BIPAP)
- Intubation and long-term mechanical ventilation

Future Hospitalization/Transfer

- Do not send to hospital unless pain or severe symptoms cannot otherwise be controlled
- Send to hospital if necessary, based on MOLST orders.

Artificially Administered Fluids and Nutrition

- No feeding tube
- A trial period of feeding tube
- Long-term feeding tube
- No IV fluids
- A trial period of IV fluids

Antibiotics

- Do not use antibiotics
- Limited use of antibiotics
- Use antibiotics

Other Instructions (e.g. dialysis, transfusions)

If any part of Section E is completed, additional consent and a physician signature, similar to Section B, must be documented at the end of this section. Sometimes two boxes will be checked in Section E. If the form was completed in the community (as opposed to a hospital or nursing home), a Public Health Law Surrogate may consent to a nonhospital DNR and/or DNI order, but may not consent to withholding other life-sustaining treatment unless the consent is based on clear and convincing evidence of the patient's wishes. For that reason, the box for "based on clear and convincing evidence of the patient's wishes" may be checked in addition to the box for "Public Health Law Surrogate."

Liability Protection

PHL § 2994-gg provides: "No person shall be subjected to criminal prosecution or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring reasonably and in good faith pursuant to this section a nonhospital order not to resuscitate, for disregarding a nonhospital order pursuant to section twenty-nine hundred ninety-four-ee of this article, or for other actions taken reasonably and in good faith pursuant to this section."

Frequently Asked Questions

What should I do if I am uncertain how to proceed?

Contact Medical Control.

What do I do if the patient has both a nonhospital DNR order and a MOLST form? Which do I honor?

If the forms have different orders, you should follow the form that has the most recently dated authorization. In all instances you should follow the DNI instructions on the MOLST form if the form is signed by a physician, as the nonhospital DNR order does not provide this advice.

What if the old MOLST form was signed prior to June 1, 2010, the date the Family Health Care Decisions Act became effective?

You may honor the previous versions of the form as if it were authorized after the statutory effective date.

Does the MOLST law allow EMS to honor other advance directives?

The law does not expand the ability of EMS personnel to honor advance directives such as a Health Care Proxy or Living Will.

What procedures are, and are not, performed if the patient presents a DNR?

Do not resuscitate (DNR) means, for the patient in cardiac or respiratory arrest (i.e., when the patient has no pulse and/or is not breathing), NO chest compressions, ventilation, defibrillation, endotracheal intubation, or medications. If the patient is NOT in cardiac or respiratory arrest, full treatment for all injuries, pain, difficult or insufficient breathing, hemorrhage and/or other medical conditions must be provided, unless Section E of the MOLST form provides different instructions. Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped, ventilation should not be assisted.

CPR must be initiated if no Out of Hospital or facility DNR is presented. If a DNR order is presented after CPR has been started, stop CPR.

What documentation is required for a patient with a DNR order?

Prehospital care providers should attach a copy of the Out of Hospital DNR form, MOLST form, hospital DNR order and/or copy of the patient's chart to the patient care report, along with all other usual documentation. It should be noted on the patient care report that a written DNR order was present including the name of the phy-sician, date signed and other appropriate information.

If the cardiac/respiratory arrest occurred during transport, the DNR form should accompany the patient so that it may be incorporated into the medical record at the receiving facility.

Patients who are identified as dead at the scene need not be transported by ambulance; however, local EMS agencies should consider transportation for DNR patients who collapse in public locations. In these cases it may be necessary to transport the individual to a hospital without resuscitative measures in order to move the body to a location that provides privacy. Local policies need to be coordinated with the Medical Examiner/Coroner and law enforcement.

MOLST Training

EMS providers and agencies who are interested in more specific training regarding the MOLST form and process may go to http://www.compassionandsupport.org. This site has a specific training program for EMS providers. The site contains frequently asked questions and a training video that would be useful to better understand the MOLST form and process.

If you have other questions about this policy guidance please contact your DOH Regional EMS office or you may call 518-402-0996.

Resources

New York State Department of Health MOLST Information:

- http://www.health.state.ny.us/professionals/patients/patient_rights/molst/index.htm

MOLST Forms

- http://www.health.state.ny.us/forms/doh-5003.pdf

Compassion and Support Website:

- http://www.compassionandsupport.org

MOLST Training Center:

- http://www.compassionandsupport.com/index.php/for_professionals/molst_training_center

MOLST EMS Training Page:

- http://www.compassionandsupport.com/index.php/for_professionals/molst_training_center/ems_molst_training

Issued and authorized by Lee Burns, Acting Director of the Bureau of EMS

PROTOCOL APPENDICES

APPENDIX D

AUTOMATED EXTERNAL DEFIBRILLATION (AED) GUIDELINES

Appendix D has been deleted.

APPENDIX E
GLASGOW COMA SCALES/TRAUMA SCORES

ADULT GLASGOW COMA SCALE

RESPONSE		POINTS
Eye Opening	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
Verbal Response	Oriented	5
	Confused	4
	Inappropriate words	3
	Incomprehensible words	2
	None	1
Motor Response	Obeys commands	6
	Localizes pain	5
	Withdraws to pain	4
	Flexion	3
	Extension	2
	None	1
Total Glasgow Coma Scale		**3 – 15 Points**

ADULT TRAUMA SCORE

RESPONSE		POINTS
Respiratory Rate	10-29/min	4
	> 29/min	3
	6-9/min	2
	1-5/min	1
	None	0
Systolic BP	> 89 mmHg	4
	76-89 mmHg	3
	50-75 mmHg	2
	1-49 mmHg	1
	None	0
Glasgow Coma Scale Points	13-15	4
	9-12	3
	6-8	2
	4-5	1
	3	0
Total Trauma Score		**0 – 12 Points**

APPENDIX E (continued)
GLASGOW COMA SCALES/TRAUMA SCORES

INFANT GLASGOW COMA SCALE

RESPONSE		POINTS
Eye Opening	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
Verbal Response	Coos, Babbles	5
	Irritable Cries	4
	Cries To Pain	3
	Moans To Pain	2
	None	1
Motor Response	Normal Spontaneous Movement	6
	Withdraws To Touch	5
	Withdraws to pain	4
	Abnormal Flexion	3
	Abnormal Extension	2
	None	1
Total Glasgow Coma Scale		**3 – 15 Points**

PEDIATRIC TRAUMA SCORE

RESPONSE		POINTS
Size	> 20 Kg	+2
	10-20 Kg (22-44 lbs)	+1
	< 10 Kg (22 lbs)	-1
Airway	Normal	+2
	Maintainable	+1
	Unmaintainable	-1
Systolic BP	> 90 mmHg	+2
	50-90 mmHg	+1
	<50 mmHg	-1
CNS	Awake	+2
	Obtunded / LOC	+1
	Coma / Cerebrate	-1
Open Wounds	None	+2
	Minor	+1
	Major / Penetrating	-1
Skeletal	None	+2
	Closed Fractures	+1
	Open / Multiple fractures	-1
Total Trauma Score		**-6 – +12 Points**

APPENDIX F

TRAUMA PATIENT CRITERIA

Adult Major Trauma

Major trauma present if the patient's physical findings or the mechanism of injury meets **any one** of the following criteria:

PHYSICAL FINDINGS

1. Glasgow Coma Scale is less than or equal to 13
2. Respiratory rate is less than 10 or more than 29 breaths per minute
3. Pulse rate is less than 50 or more than 120 beats per minute
4. Systolic blood pressure is less than 90 mmHg
5. Penetrating injuries to head, neck, torso or proximal extremities
6. Two or more suspected proximal long bone fractures
7. Suspected flail chest
8. Suspected spinal cord injury or limb paralysis
9. Amputation (except digits)
10. Suspected pelvic fracture
11. Open or depressed skull fracture

MECHANISM OF INJURY

1. Ejection or partial ejection from an automobile
2. Death in the same passenger compartment
3. Extrication time in excess of 20 minutes
4. Vehicle collision resulting in 12 inches of intrusion in to the passenger compartment
5. Motorcycle crash >20 MPH or with separation of rider from motorcycle
6. Falls from greater than 20 feet
7. Vehicle rollover (90 degree vehicle rotation or more) with unrestrained passenger
8. Vehicle vs. pedestrian or bicycle collision above 5 MPH

HIGH RISK PATIENTS – **DOES NOT REQUIRE TRANSPORT TO A TRAUMA CENTER**

If a patient does not meet the above criteria for Major Trauma, but has sustained an injury and has one or more of the following criteria, they are considered a "High Risk Patient".
CONSIDER transportation to a Trauma Center.
CONSIDER contacting medical control.

1. Bleeding disorders or patients who are on anticoagulant medications
2. Cardiac disease and/or respiratory disease
3. Insulin dependent diabetes, cirrhosis, or morbid obesity
4. Immuno-suppressed patients (HIV disease, transplant patients, and patients on chemotherapy treatment)
5. Age >55

APPENDIX G
BURN PATIENT CRITERIA

For adults and pediatric patients with 2nd and 3rd degree cutaneous burns:

1. Burns involving 15% or more of the total body surface area.
2. Third degree burns involving 5% or more of the total body surface area.
3. Burns involving 9% or more of the total body surface area in persons:
   - Under 5 or over 60 years of age

   OR

   - With a pre-existing disease which may complicate or retard recovery
4. Respiratory burns.
5. Electrical burns.
6. Burns involving the eyes, ears, face, hands, feet, or genitalia.
7. Burns with associated trauma.

NOTE: **MAJOR BURN PATIENTS SHOULD BE TRANSPORTED TO A BURN CENTER. (SEE APPENDIX H.)**

PATIENTS IN CARDIAC ARREST OR WITH OBSTRUCTED OR UNMANAGEABLE AIRWAYS SHOULD BE TRANSPORTED TO THE NEAREST 911 AMBULANCE DESTINATION EMERGENCY DEPARTMENT. (SEE APPENDIX I.)

PROTOCOL APPENDICES

APPENDIX H
FACILITIES PROVIDING SPECIALTY CARE

TRAUMA CENTERS	**Brooklyn**	Brookdale Hospital
		Kings County Hospital
		Lutheran Medical Center
	Bronx	Jacobi Hospital
		Lincoln Medical Center
		St. Barnabas Hospital
	Manhattan	Bellevue Medical Center
		Harlem Hospital
		New York Presbyterian Hospital (Cornell Campus)
		New York Presbyterian Hospital (Columbia Campus) – **Pediatric Trauma Only**
		St. Luke's/Roosevelt Medical Center (St. Luke's Division) – **Adult Trauma Only**
	Queens	Elmhurst General Hospital
		Jamaica Hospital
		North Shore University Hospital (Long Island Jewish-Hillside Campus/Schnieder Children's Hospital) – **Pediatric Trauma Only**
		New York Medical Center of Queens
	Staten Island	Richmond University Medical Center of SI
		Staten Island University Hospital (North Division)

BURN CENTERS	**Bronx**	Jacobi Hospital
	Manhattan	Harlem Hospital
		New York Presbyterian Hospital (Cornell Campus)
	Staten Island	Staten Island University Hospital (North Division)

SPINAL CORD INJURY CENTER	**Manhattan**	Bellevue Hospital Center

REPLANTATION CENTERS	**Bronx**	Montefiore Medical Center
	Manhattan	Bellevue Hospital Center

HYPERBARIC CENTER	**Bronx**	Jacobi Hospital

VENOMOUS BITE CENTER	**Bronx**	Jacobi Hospital

PROTOCOL APPENDICES

APPENDIX I
HOSPITAL LISTINGS
(AMBULANCE DESTINATIONS)

MANHATTAN

FDNY Hospital #	FACILITY	ADDRESS	Upper Pediatric Age Limits
02	Bellevue Hospital Center	472 First Avenue New York, NY 10016	25
03	Beth Israel Medical Center – Petrie Campus	10 Nathan D. Perlman Place New York, NY 10003	17
07	Harlem Hospital Center	506 Lenox Avenue New York, NY 10037	18
11	Lenox Hill Hospital	100 East 77th Street New York, NY 10021	17
	Manhattan Eye/Ear/Throat Hospital	210 East 64th Street New York, NY 10021	
	Department of Veterans Affairs Harbor Health Care- New York Campus	1st Avenue & 23rd Street New York, NY 10016	
	Memorial Sloan Kettering Hospital	1275 York Avenue New York, NY 10021	
12	Metropolitan Hospital Center	1901 First Avenue New York, NY 10029	18
13	Mount Sinai Medical Center Hospital	One Gustave L. Levy Plaza New York, NY 10029	21
	New York Eye & Ear Infirmary	Second Avenue & 14th Street New York, NY 10003	
14	New York Presbyterian Hospital - New York Weill Cornell Campus	525 East 68th Street New York, NY 10021	Pending
01	New York University Downtown Hospital	170 William Street New York, NY 10038	Not listed
15	New York University Medical Center – Tisch Hospital	550 First Avenue New York, NY 10016	Not listed
17	New York Presbyterian Hospital-Columbia Presbyterian Medical Center	622 West 168th Street New York, NY 10032	19
16	New York Presbyterian Hospital - Allen Pavilion	5141 Broadway New York, NY 10034	Not listed
18	St. Luke's/Roosevelt Hospital Center St. Luke's Hospital Division	Amsterdam Avenue and 114th Street New York, NY 10025	Not listed
20	St. Luke's/Roosevelt Hospital Center Roosevelt Hospital Division	428 West 59th Street New York, NY 10019	21

Italics indicate non-911 destination facility

BRONX

FDNY Hospital #	FACILITY	ADDRESS	Upper Pediatric Age Limits
23	Bronx Lebanon Hospital Center – Concourse Division	1650 Grand Concourse Bronx, NY 10457	18
	Bronx Lebanon Hospital Center – Fulton Division	1276 Fulton Avenue Bronx, NY 10456	
	Bronx VA Medical Center	Sedgewick Avenue Bronx, NY 10400	
25	Jacobi Medical Center	1400 Pelham Parkway South Bronx, NY 10461	18
27	Lincoln Medical & Mental Health Center	234 East 149th Street Bronx, NY 10451	18
29	Montefiore Medical Center – Moses Division	111 East 210th Street Bronx, NY 10467	Not listed
70	North Central Bronx Hospital	3424 Kossuth Avenue Bronx, NY 10467	18
28	Montefiore Medical Center – North Division	600 East 233rd Street Bronx, NY 10466	21
83	St. Barnabas Hospital	4422 Third Avenue Bronx, NY 10457	17
22	Montefiore Medical Center – Weiler Division	1825 Eastchester Road Bronx, NY 10467	21
88	NY Westchester Square Hospital Medical Center	2475 Raymond Avenue Bronx, NY 10401	

WESTCHESTER

FDNY Hospital #	FACILITY	ADDRESS	Upper Pediatric Age Limits
	Lawrence Hospital	55 Palmer Avenue Bronxville, NY 10708	
	Saint John's Riverside Hospital	967 North Broadway Yonkers, NY 10701	
	Saint Joseph's Medical Center	127 South Broadway Yonkers, NY 10701	
	Sound Shore Medical Center of Westchester	16 Guion Place New Rochelle, NY 10802	
	The Mount Vernon Hospital	12 North 7th Avenue Mount Vernon, NY 10550	
	Westchester Medical Center	95 Grasslands Road Valhalla, NY 10595	

Italics indicate non-911 destination facility

BROOKLYN

FDNY Hospital #	FACILITY	ADDRESS	Upper Pediatric Age Limits
93	Beth Israel Medical Center – Kings Highway Division	3201 Kings Highway Brooklyn, NY 11234	
41	Brookdale University Hospital Medical Center	Linden Boulevard at Brookdale Plaza Brooklyn, NY 11212	18
	Department of Veterans Affairs Harbor Health Care- Brooklyn Campus	Poly Place & 7th Avenue Brooklyn, NY 11213	
42	Coney Island Hospital	2601 Ocean Parkway Brooklyn, NY 11235	18
55	Interfaith Medical Center - St. John's Division	1545 Atlantic Avenue Brooklyn, NY 11213	
48	Kings County Hospital Center	451 Clarkson Avenue Brooklyn, NY 11203	18
47	Kingsbrook Jewish Medical Center	585 Schenectady Avenue Brooklyn, N. Y. 11203	18
49	Long Island College Hospital	339 Hicks Street Brooklyn, NY 11201	18
51	Lutheran Medical Center	150 55th Street Brooklyn, NY 11220	17
53	Maimonides Medical Center	4802 Tenth Avenue Brooklyn, NY 11220	17
92	New York Community Hospital of Brooklyn	2525 Kings Highway Brooklyn, NY 11229	Not listed
54	New York Methodist Hospital	506 Sixth Street Brooklyn, NY 11215	20
95	The Brooklyn Hospital Center	121 DeKalb Avenue Brooklyn, NY 11201	Not listed
44	University Hospital of Brooklyn-SUNY Downstate Medical Center	445 Lenox Road Brooklyn, NY 11203	18
45	Woodhull Medical & Mental Health Center	760 Broadway Brooklyn, NY 11206	
58	Wyckoff Heights Medical Center	374 Stockholm Street Brooklyn, NY 11237	

Italics indicate non-911 destination facility

QUEENS

FDNY Hospital #	FACILITY	ADDRESS	Upper Pediatric Age Limits
32	Elmhurst Hospital Center	79-01 Broadway Elmhurst, NY 11373	
33	Flushing Hospital Medical Center	45-00 Parsons Boulevard Flushing, NY 11355	17
34	Jamaica Hospital	89th Avenue & Van Wyck Expressway Jamaica, NY 11418	17
35	Long Island Jewish Hillside Medical Center	270-05 76th Avenue New Hyde Park, NY 11042	18
31	New York Hospital Medical Center of Queens	56-45 Main Street Flushing, NY 11355	21
77	North Shore University Hospital – Forest Hills	102-01 66th Road Forest Hills, NY 11375	Not listed
37	Peninsula Hospital Center	51-15 Beach Channel Drive Far Rockaway, NY 11691	17
38	Queens Hospital Center	82-68 164th Street Jamaica, NY 11432	
40	St. John's Episcopal Hospital – South Shore Division	327 Beach 19th Street Far Rockaway, NY 11691	
71	Mount Sinai Hospital of Queens	25-10 30th Avenue Long Island City, N. Y. 11102	Permanent Diversion

NASSAU

FDNY Hospital #	FACILITY	ADDRESS	Upper Pediatric Age Limits
74	Franklin Hospital Medical Center	900 Franklin Avenue Valley Stream, NY 11580	Not listed
68	Mercy Medical Center	1000 North Village Avenue Rockville Centre, NY 11571	
	Nassau University Medical Center	2201 Hempstead Turnpike East Meadow, NY 11501	
78	North Shore University Hospital Center Manhasset	300 Community Drive Manhasset, NY 11030	18
	Saint Francis Hospital	100 Port Washington Blvd. Roslyn, NY 11576	
	Winthrop University Hospital	259 First Street Mineola, NY 11501	

Italics indicate non-911 destination facility

PROTOCOL APPENDICES

RICHMOND

FDNY Hospital #	FACILITY	ADDRESS	Upper Pediatric Age Limits
60	Richmond University Medical Center	355 Bard Avenue Staten Island, NY 10310	18
62	Staten Island University Hospital – North Ocean Breeze Campus	475 Seaview Avenue Staten Island, NY 10305	21
59	Staten Island University Hospital – South Prince's Bay Campus	375 Seguine Avenue Staten Island, NY 10309	Not listed

Italics indicate non-911 destination facility

PROTOCOL APPENDICES

APPENDIX J

PEDIATRIC VITAL SIGNS

Appendix J has been deleted.

For Pediatric equipment and dosing values, refer to Length Based Dosing Device.

PROTOCOL APPENDICES

APPENDIX K
APGAR SCORING SYSTEM

The patient is scored 0 - 2 points for each clinical sign. Maximum total score is 10. The score is determined at 1 and 5 minutes of life. The higher the score, the better.

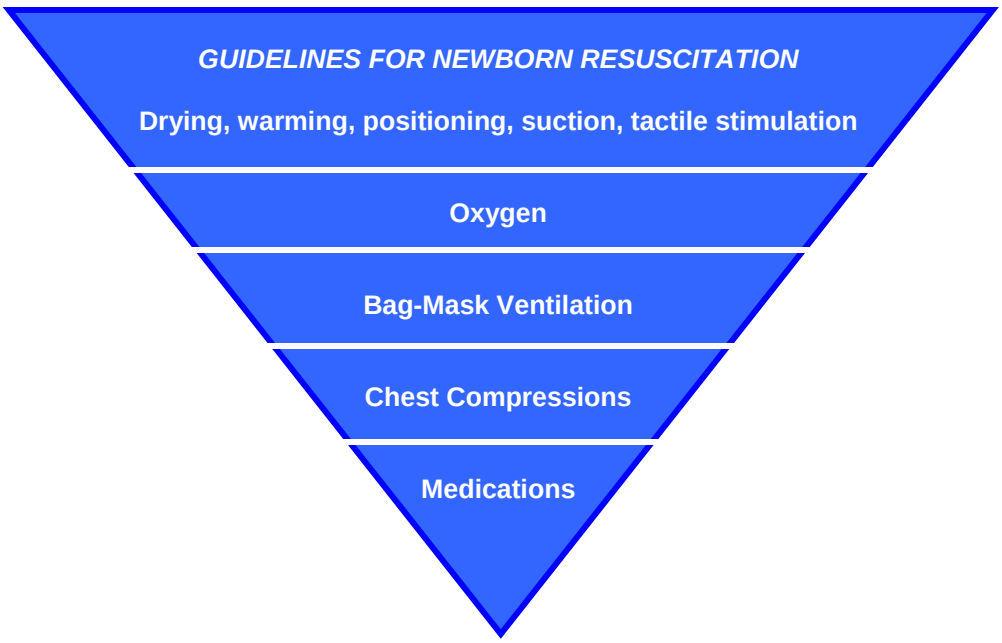
SIGN	0	1	2
Heart Rate	Absent	Below 100	Over 100
Respiration (effort)	Absent	Slow and irregular	Normal; crying
Muscle Tone	Limp	Some flexion - extremities	Active; good motion in extremities
Irritability	No Response	Crying: some motion	Crying; vigorous
Skin Color	Bluish or pale	Pink or typical newborn color; hands and feet are blue	Pink or typical newborn color; entire body

A score of:

8 - 10 is generally normal
5 - 7 indicates a need for supplemental oxygen
3 - 4 indicates a need for Bag-Valve-Mask ventilation
0 - 2 generally indicates a need for CPR

NOTE: **A SCORE OF 7 OR LESS REQUIRES IMMEDIATE INTERVENTION. (SEE PROTOCOL # 443).**

THE MANAGEMENT OF RESPIRATORY DISTRESS OR CARDIOVASCULAR INSTABILITY TAKES PRIORITY OVER OBTAINING APGAR SCORE.



APPENDIX L
TRIAGE / S. T. A. R. T.

The **S.T.A.R.T**. plan (**S**imple **T**riage **A**nd **R**apid **T**reatment) was developed by the Los Angles County Fire Chiefs to be used in the event of a Multiple Casualty Incident (MCI).

This plan allows EMTs and Paramedics to triage patients at an MCI in 60 seconds or less.

It is based on three (3) observations:

1. Respirations;
2. Circulation; and,
3. Mental Status.

Most trauma patients die within the first hour (Golden Hour) after sustaining their injuries, mostly due to respiratory complications/insufficiency, exsanguination, or CNS trauma.

Review of MCIs and Triage

An MCI is any sudden event or situation that has produced, is believed to have produced, or experience indicates, may produce a minimum of five (5) patients.

Triage is a French word meaning to sort. Its purpose is to identify patients with life threatening injuries and give them immediate treatment and transportation.

Aim of Triage: GREATEST GOOD FOR THE GREATEST NUMBER

Principles of S.T.A.R.T.

The **S.T.A.R.T.** plan calls for rescuers to correct immediate threats to life:
blocked airways; and
severe arterial bleeding.

The **S.T.A.R.T.** plan utilizes the METTAGE Triage Card, which classifies patients into four (4) distinct areas for treatment.

It is a system that quickly and accurately triages victims into treatment groups.

The plan is simple to learn and retain. It is extremely useful in the MCI setting in that it maximizes the efficiency of the rescuers until additional resources arrive.

Prior to the **S.T.A.R.T.** plan, triage was solely based on individual judgment. If the injury appeared serious, the patient was placed in a critical treatment area. **S.T.A.R.T.** provides specific criteria for triage of patients.

How S.T.A.R.T. Works

The Triage Team must evaluate and place the patient's injuries into one of four categories:

DECEASED (BLACK TAG): No spontaneous effective respirations present after one attempt to reposition the airway.

IMMEDIATE (RED TAG): Respirations present only after repositioning of the airway.

Applies to patients with respiratory rates greater than 30 per minute.

Patients whose capillary refill is delayed more than 2 seconds.

The patient fails to follow simple commands.

DELAYED (YELLOW TAG): Any patient who does not fit into the IMMEDIATE category or the MINOR category.

MINOR (GREEN TAG): Patients who are separated from the general group at the beginning of the triage operation. These patients are also called the "walking wounded".

These patients are directed to walk away from the scene to a designated safe area.

These patients can also be utilized to control severe bleeding and assist in maintenance of patent airways on those "IMMEDIATE" patients who require it.

PROCEDURE

Respiratory Assessment

1. Every patient will be quickly assessed for respiratory rate and adequacy.
2. If a patient is not breathing, check for foreign objects causing obstruction in the mouth. Remove dentures if they are loose.
3. Reposition the head, using cervical spine precautions if this does not delay assessment.
4. If the above maneuvers do not result in effective spontaneous respirations, **TAG THE PATIENT BLACK.**
5. If the patient's respiratory rate is greater than 30 per minute, **TAG THE PATIENT RED.**
6. Patients who have respirations less than 30 per minute are **NOT TO BE TAGGED AT THIS TIME. THEY ARE TO BE ASSESSED IN THE NEXT CATEGORY.**

Perfusion

1. The best indicator of adequate perfusion is an assessment of capillary nail-bed refill.
2. Press nailbeds or lips and release. Color should return to these areas within 2 seconds.
    a. If it takes more than 2 seconds, the patient is showing signs of inadequate perfusion **AND MUST BE TAGGED RED.**
    b. If the color returns within 2 seconds or less, **THE PATIENT IS NOT TAGGED UNTIL THE NEXT AREA IS ASSESSED** - Mental Status.
3. If the capillary refill cannot be assessed, palpate the radial pulse. In most cases, if the radial pulse cannot be felt, the systolic blood pressure will be below 80 mm Hg.
4. Hemorrhage control techniques will be incorporated into this section. Control significant bleeding by direct pressure and elevate the lower extremities.
5. Utilize the "walking wounded" to assist with hemorrhage control on themselves or other patients.

Mental Status

1. An evaluation of mental status is performed on patients whose respirations and perfusion are adequate. To test mental status, the rescuer should ask the patient to follow a simple command,
2. e.g., "open and close your eyes" or, "squeeze my hands."
3. If the patient **cannot** follow these commands, s/he is **TAGGED RED.**
4. If the patient **can** follow these commands, s/he is **TAGGED YELLOW.**
5. Only after all patients have been triaged can patients be treated. The above techniques should take no more than 60 seconds per patient.

Triage Tags

Triage tags are completed during transportation to the hospital or in the Staging Area, if there is time.

To fill out the triage tag properly, follow these instructions:

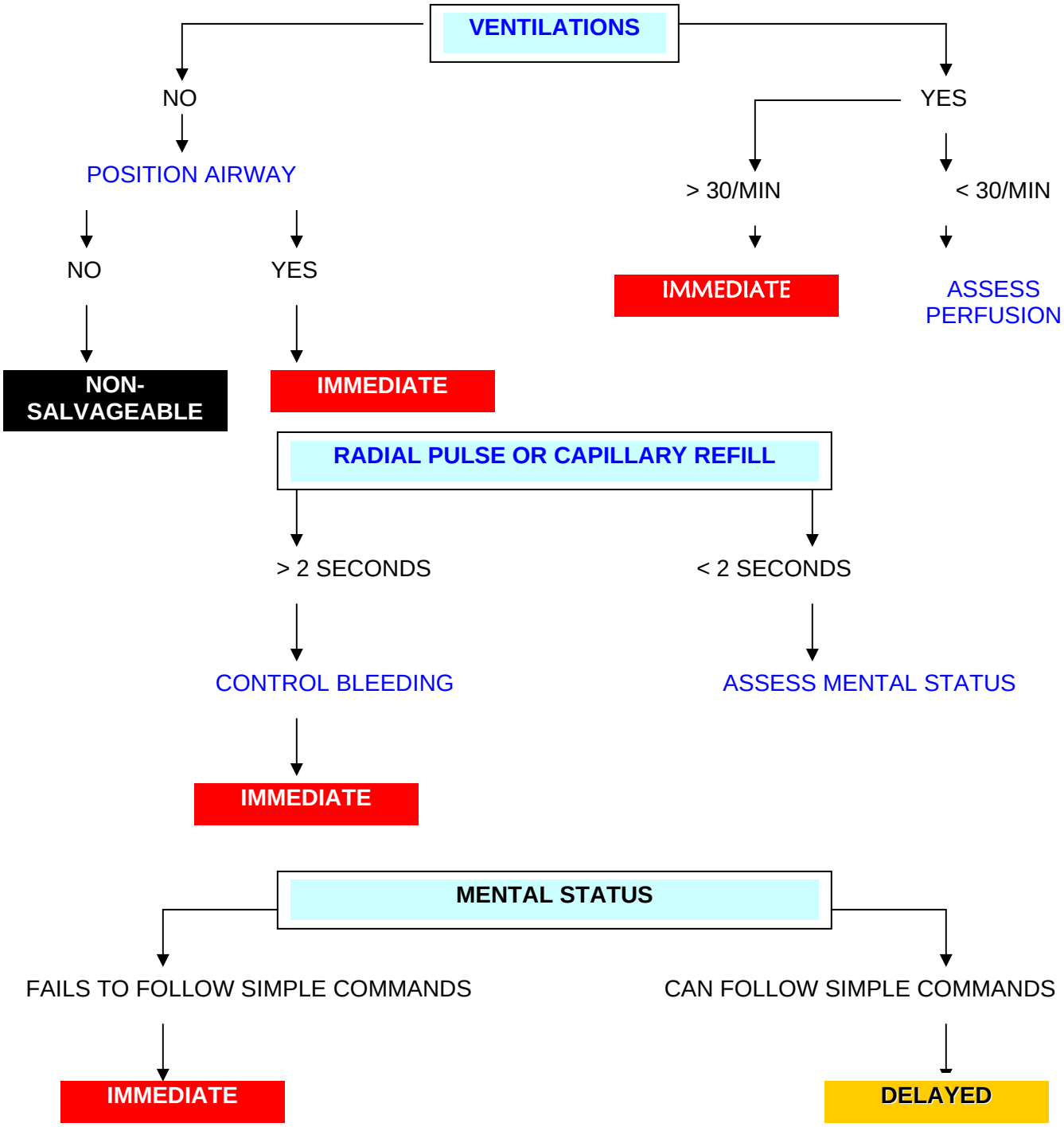
1. record time of triage
2. record the date
3. ***** record the name of the patient if s/he is conscious and coherent
4. ***** record the home address of the patient if possible
5. ***** record the home city and state of the patient if possible
6. record other important information, i.e. medical treatment, history
7. record your shield number or EMT number on the bottom line and on the yellow corners
8. on the reverse side, record injuries on the diagram
9. record vital signs and the time taken in the indicated areas
10. paramedics will record IVs and any drugs given
11. tear off all colored areas **BELOW** the determined priority and retain
12. attach tag securely to clothing or body so that it is clearly visible

Left and right corners (Ambulance & Cross) are perforated along the lines.

1. Make sure that your shield or EMT number appears on both corners.
2. The corner marked with the **CROSS** is removed in the treatment area prior to removal to a medical facility. These should be given to the person or Supervisor in charge of the Treatment Area.
3. The corner marked with the **AMBULANCE** is to be removed prior to the actual transfer of the patient from the Treatment Area to a medical facility. It is to be retained by the crew until the end of the MCI. These are then given to the person or Supervisor in charge of the Transportation Area.
4. All the initial triage portions of the tags must be retained by the Triage Team and given to the person, or Supervisor, in charge of the Triage Team at the end of the MCI.

***** **Items 3, 4, and 5 may be delayed or accomplished by others while awaiting transportation.**

SIMPLE TRIAGE AND RAPID TREATMENT



ALL MINOR TAGGED PATIENTS (GREEN TAG OR WALKING WOUNDED) ARE TO BE REMOVED FROM THE SCENE FIRST AND SENT TO A SAFE AREA. THESE PATIENTS CAN ALSO BE USED TO HELP WITH BLEEDING CONTROL OR AIRWAY PROBLEMS ON OTHER PATIENTS.

PROTOCOL APPENDICES

APPENDIX M
AGENCY ADDRESSES

REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL OF NEW YORK CITY 475 Riverside Drive, Suite 1929 New York, NY 11015	**REGIONAL EMERGENCY MEDICAL ADVISORY COMMITTEE (REMAC) OF NEW YORK CITY** 475 Riverside Drive, Suite 1929 New York, NY 11015
NEW YORK CITY FIRE DEPARTMENT BUREAU OF EMERGENCY MEDICAL SERVICES 9 MetroTech Center Brooklyn, NY 11201	**NEW YORK CITY POLICE DEPARTMENT** 1 Police Plaza New York, NY 10038
AMTRAK POLICE 400 North Capital Street Washington, DC 20002	**LONG ISLAND RAILROAD SERVICE** Jamaica Station Jamaica, NY 11435
METRO-NORTH COMMUTER POLICE Grand Central Station Room #1750 New York, NY 10017	**NEW YORK STATE POLICE** c/o Principal Clerk Troop L Headquarters 3045 Sunrise Highway Islip Terrace, NY 11752
NEW YORK STATE DEPARTMENT OF HEALTH Bureau of Emergency Medical Services 433 River Street, Suite 303 Troy, NY 12180-2299	**NEW YORK CITY FIELD OFFICE EMS** New York State Department of Health & Systems Management 90 Church Street, 15th Floor New York, NY 10007

PROTOCOL APPENDICES

APPENDIX N
LANDMARKS AND PROCEDURE FOR NEEDLE CRICOTHYROIDOTOMY

Appendix N has been deleted.

NEEDLE CRICOTHYROIDOTOMY HAS BEEN REMOVED FROM THE PREHOSPITAL TREATMENT PROTOCOLS

APPENDIX O
LANDMARKS AND PROCEDURE FOR DECOMPRESSION OF A TENSION PNEUMOTHORAX

1. Confirm the need for Needle Decompression:

    a) **Respiratory distress**

        i) dyspnea;

        ii) tachypnea;

        iii) cyanosis; and/or

        iv) chest pain;

    b) **Absent** or **decreased breath sounds** on the affected side; **and**

    c) A **deviated trachea** away from the side of the injury.

2. Administer high concentration oxygen.

3. Identify the second intercostal space on the mid-clavicular line on the same side as the Pneumothorax.

4. Cleanse the overlying skin with Povidone Iodine solution.

5. Insert a #l4 gauge, 3 - 6 cm long (adult) or a #18 - 20 gauge, 2 - 4 cm long (child or infant) over-the-needle catheter into the skin **above** the third rib and direct it just **over** the rib into the interspace.

6. Insert the catheter through the parietal pleura until air exits under pressure.

7. Remove the needle and leave the plastic cannula in place until it is replaced in the Emergency Department.

8. Attach a ***flutter valve*** to the end of the plastic cannula and secure the cannula for transportation.

APPENDIX P

USE OF THE CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE

Scope: In the event of acute congestive heart failure, Paramedics trained and authorized by the service medical director, may utilize Continuous Positive Airway Pressure (CPAP), if available and appropriate.

INCLUSION CRITERIA

1. Be at least 18 years of age
2. Be Alert
3. Be able to maintain an open and patent airway on their own
4. Have a blood pressure of at least 100 mm Hg systolic
5. Have significant respiratory distress, indicated by cyanosis, accessory muscle use or other signs and symptoms.

CONTRAINDICATIONS

1. Less than 18 years of age
2. Need for immediate Endotracheal Intubation or other methods of airway control
3. Altered Mental Status or unresponsive patients
4. Hemodynamically unstable patients
5. Patients who are unable to control their own airway
6. Trauma, facial burns, impending respiratory or cardiac arrest
7. **Known** Active unstable angina or acute myocardial infarction
8. Uncooperative patient
9. Pregnancy
10. **Known** Pneumonia, pneumothorax, anaphylaxis, pulmonary embolism, or aspiration.
11. Gastric Distention

CPAP IS TO BE IMMEDIATELY DISCONTINUED IF:

1. An immediate need for advanced airway control arises
2. The patient becomes hemodynamically unstable
3. The patient cannot tolerate the mask due to pain or discomfort

APPENDIX Q
ADMINISTRATION OF RECTAL VALIUM

INCLUSION CRITERIA

1. Diazepam may be administered via the rectum only if no other route of administration is available. (Refer to REMAC ALS Protocol 557 – Pediatric Seizures).
2. Administration of Rectal Diazepam is a medical control option.

PROCEDURE FOR RECTAL ADMINISTRATION OF DIAZEPAM

1. The dosage of Diazepam for rectal administration is .5 mg/kg.
2. The Diazepam is to be drawn up in a 1 cc (i.e., Tuberculin) syringe, and the needle then removed from the syringe.
3. When possible and practical, place the pediatric patient prone on the lap of a parent and have them assist you in spreading the patient's buttocks apart. This will allow the parent to see what is happening and help reduce patient agitation.
4. The syringe may be lubricated with an acceptable water-based medical lubrication prior to insertion in the patient's rectum.
5. The ALS provider should then carefully insert the tip of the syringe approximately 4 to 5 cm, or about half the total length of the 1 cc syringe into the patient's rectum.
6. The Diazepam is then administered into the rectum, and the syringe carefully removed.
7. If there is concern about expulsion following rectal administration, the paramedic may tape the patient's buttocks closed using one (1) piece of 2 inch tape.

POTENTIAL COMPLICATIONS

1. Exercise great care while inserting the syringe into the patient's rectum to avoid perforating rectal tissue and/or causing local tissue damage.
2. Do not push the syringe too deeply into the rectum since the blood supply deep in the rectum passes through the liver prior to entering into central circulation. Minimal penetration will reduce the chance of decreasing the effectiveness of the Diazepam due to metabolic actions by the liver. This will also allow the Diazepam to circulate longer in the central circulation, and be more effective in seizure suppression.
3. The presence of feces in the rectum may inhibit the absorption of the Diazepam. If the Diazepam does not take effect within ten (10) minutes and the arrival of the patient at the hospital is not imminent, consider re-contacting the Medical Control for further direction. However, it is not recommended that the dosage of Diazepam exceed 10 mg.
4. When administering Diazepam to neonates, note that metabolism of Diazepam may take longer and the expected therapeutic effects may last longer.

PROTOCOL APPENDICES

APPENDIX R

STROKE PATIENT CRITERIA

Patients exhibiting signs and symptoms of a stroke (CVA):

1. Utilize the modified Cincinnati Pre-Hospital Stroke Scale (PSS):
    a. Assess for facial droop: have the patient show teeth or smile,
    b. Assess for arm drift: have the patient close eyes and hold both arms straight out for 10 seconds,
    c. Assess for abnormal speech: have the patient say a simple sentence, for example: "you can't teach an old dog new tricks."

2. If any **one** of the findings of the modified Cincinnati Pre-Hospital Stroke Scale are positive, establish onset of signs and symptoms by asking the following :
    a. To patient – "When was the last time you remember before you became weak, paralyzed, or unable to speak clearly?"
    b. To family or bystander – "When was the last time you remember before the patient became weak, paralyzed, or unable to speak clearly?"
    c. If the patient woke with the deficit, the time of onset is the time patient went to sleep.
3. If the historical/physical findings indicate an acute stroke, transport the patient to the nearest NYS DOH designated Stroke Center (See Appendix R, Stroke Patient Criteria), unless **one** of the following conditions is met:
    a. The patient is in cardiac arrest;
    b. The patient has other medical conditions that warrant transport to the nearest appropriate hospital emergency department as per protocol;
    c. The total time from when the patient's symptoms and/or signs first began to when the patient is first assessed by EMS is greater than **three and one half (3 ½) hours**;
    d. The closest NYS DOH designated Stroke Center is **more** than 20 minutes away;
    e. An on-line medical control physician so directs .

APPENDIX S

New York City Burn Disaster Receiving Hospitals

Current List of New York City Burn Disaster Receiving Hospital (BDRH) Locations and Tier

Name of Hospital	BDRH Tier
Jacobi Medical Center	1
Harlem Hospital Center	1
New York Presbyterian/Weill Cornell	1
Staten Island University Hospital (North)	1
Lincoln Medical and Mental Health Center	2
St. Barnabas Hospital	2
Brookdale University Hospital Medical Center	2
Kings County Hospital	2
Lutheran Medical Center	2
Bellevue Hospital Center	2
New York Presbyterian/Children's Hospital	2
St. Luke's Roosevelt Hospital Center	2
Elmhurst Hospital Center	2
Jamaica Hospital Medical Center	2
New York Hospital Queens	2
Richmond University Medical Center	2
Montefiore Medical Center	3
North Central Bronx Hospital	3
Coney Island Hospital	3
Kingsbrook Jewish Medical Center	3
Maimonides Medical Center	3
Wyckoff Heights Medical Center	3
Metropolitan Hospital Center	3
Mount Sinai Medical Center	3
NYP/Columbia	3
NYU Hospitals Center	3
Flushing Hospital Medical Center	3
Forest Hills Hospital	3

PROTOCOL APPENDICES

APPENDIX T
USE OF TOURNIQUETS [1]

Scope: To reduce or stop severe extremity hemorrhage that cannot be controlled by direct pressure, by applying mechanical circumferential pressure to an open wound.

Choice of Tourniquet:

1. A tourniquet with a wider band is more effective at controlling bleeding than a very narrow one. The wider the tourniquet, the lower the pressure that is required to stop the bleeding. A tourniquet that is at least one inch wide is less likely to damage the surrounding tissues, including other vessels and nerves. Therefore, narrow tourniquets (like a thin string or wire) should be avoided.
2. Please see the most recent TCCC guidelines for a list of suggested commercial tourniquets. [http://www.naemt.org/education/PHTLS/TCCC.aspx]

Application Process:

1. Apply direct pressure.
2. Apply pressure dressings.
3. If these fail to control the bleeding, apply a tourniquet 2-3 inches proximal to the bleeding site.
4. Tighten the tourniquet until the bleeding stops and distal pulses are lost.
    a. If bleeding continues or the patient has positive distal pulses, apply a second tourniquet parallel and proximal to the first, and tighten until bleeding stops.
5. Leave the tourniquets exposed so that they can be easily seen and monitored.
6. Document the TIME of tourniquet application (1) on the PCR/ACR, and (2) on a piece of tape on or near the tourniquet.
7. Once applied, a tourniquet should not be removed in the prehospital setting.
8. A patient with a tourniquet in place should be transported to the nearest Trauma Center.

[1] Based on information from the Prehospital Trauma Life Support course