EMERGENCY DEPARTMENT
OBSERVATION UNIT

DRUG OVERDOSE
ADMISSION/DISCHARGE CRITERIA

EXCLUSION CRITERIA
1. Known ingestion of lethal material and amount
2. Unstable vital signs
3. Abnormal neurological exam including seizures, hallucinations, confusion, or narousable
4. Cardiac arrhythmias (significant)
5. Need for decontamination procedures (other than GI)
6. Body packer or stuffer
7. Ingestion of corrosives
8. Unstable respiratory status

OBSERVATION UNIT INTERVENTIONS
1. Serial exams including vital signs
2. Await toxicologic lab results (and repeat as indicated)
3. EKG monitoring
4. Pulse oximetry
5. Continued antidote administration up to 6 hours
6. Psychiatric consultation
7. Social Worker consultation

DISPOSITION
1. HOME OR PSYCHIATRIC TRANSFER
   a. Return of non-toxic lab values
   b. No change in normal exam
   c. Stable vital signs
   d. Return to pre-ingestion PE
2. HOSPITAL
   a. Return of lethal or significantly toxic lab value
   b. Deterioration in neurologic function
   c. Cardiac instability
   d. Rule in exclusionary causes
   e. Respiratory instability
   f. Unstable vital signs

TIME FRAME
1. 24 hour observation

NOT A PART OF THE MEDICAL RECORD
EMERGENCY DEPARTMENT
OBSERVATION UNIT
Overdose
Admission Orders

1. Admit to Emergency Department Observation Unit
2. Initial Emergency Department Physician: ________________________________
3. Private Physician: ________________________________ Time Contacted: ____________________
4. Consult: __________________________________________________________________________
5. Condition: ___ Stable ___ Serious
6. Copies of Emergency Department H&P on chart
7. Allergies: ______________________________________________________________________
8. Routine Vital Signs
10. Activity: ___ up ad lib ___ Other: ____________________________________________________
11. Diet: ___ Clear liquid, advance as tolerated ___ Regular ___ Other: _______________________
12. IV Fluids: ___ D5½NS + 20 meq KCl/1000ml at ___ml/hour ___ NS at ___ml/hour ___ Other: _______________________
13. Oxygen: ___ Nasal cannula @ ____ L/minute ___ Other: _______________________________
14. Medications:
___ Tylenol 1 gram po every 6 hours prn pain or fever > 101°
___ Motrin 800 mg po every 6 hours prn pain
___ Ultram 50 mg po every 6 hours prn pain
___ Maalox 30 cc po every 4 hours prn indigestion
___ Phenergan
    _____ 25mg IV every 6 hours prn nausea/vomiting
    _____ 12.5mg IV every 6 hours prn nausea/vomiting
___ Zofran
    _____ 4mg IV every 4 hours prn nausea/vomiting
    _____ 0.15mg IV every 4 hours prn nausea/vomiting
15. Re-evaluate for discharge every 3 hours

_____________________________________________  ________________________
Emergency Department Physician Signature   Date/Time
EMERGENCY DEPARTMENT
OBSERVATION UNIT

DRUG OVERDOSE
PROGRESS NOTE

Please date and sign each entry.

<table>
<thead>
<tr>
<th>DATE:</th>
<th>TIME:</th>
</tr>
</thead>
</table>

PROTOCOL: DRUG OVERDOSE

RELEVANT HISTORY/PHYSICAL FINDINGS:

<table>
<thead>
<tr>
<th>OBSERVATION INTERVENTIONS:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Serial Vital Signs</td>
<td>O(_2) % Sat Monitor if indicated</td>
</tr>
<tr>
<td>Obtain &amp; Review Tox Lab Results as indicated</td>
<td>Antidote Administration</td>
</tr>
<tr>
<td>EKG Monitor if indicated</td>
<td></td>
</tr>
</tbody>
</table>

GOALS OF OBSERVATION PERIOD:

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

HOW OFTEN WILL PATIENT BE EVALUATED BY PHYSICIAN:

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

MORNING PLAN

<table>
<thead>
<tr>
<th>PRIMARY PHYSICIAN CONTACTED:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NAME:</td>
</tr>
<tr>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

ATTENDING SIGNATURE / DATE
DATE:

TIME:

PRESENTING COMPLAINT:

OBSERVATION COURSE:
   ____ IVF
   ____ IV Antiemetics
   ____ Tolerating PO
   ____ Psychiatry consult
   ____ Antidotes given

PHYSICAL EXAM:

FINAL DIAGNOSIS:

DISPOSITION:          ____ Home    ____ Admission

DISCHARGE INSTRUCTION GIVEN:       ___ Yes      ___ No

PRIMARY PHYSICIAN CONTACTED:       ____ Yes      ____ No

NAME: _______________________________

FOLLOW UP:

ATTENDING SIGNATURE / DATE

__________________________________________________________________