**EMT/ADVANCED EMT STANDING ORDERS**
- Routine Patient Care.
- 12-lead ECG if available.

**PARAMEDIC STANDING ORDERS**

**If hemodynamically unstable:**

**For narrow complex/probable SVT:**
- Adenosine 0.1 mg/kg IV not to exceed 6 mg (first dose).
- Repeat once at 0.2 mg/kg IV not to exceed 12 mg (subsequent dose).
- If adenosine is ineffective or for wide complex, perform synchronized cardioversion:
  - 0.5 – 1 J/kg; if unsuccessful, increase to 2 J/kg.
- Administer procedural sedation prior to/during pacing, if feasible:
  - *Midazolam 0.05 mg/kg IV/IM or 0.1 mg/kg IN (maximum dose 3 mg); may repeat once in 5 minutes, OR*
  - Lorazepam 0.05 mg/kg IV/IM (maximum dose 1 mg); may repeat once in 5 minutes, **OR**
  - Diazepam 0.1 mg/kg IV (maximum dose 5 mg); may repeat once in 5 minutes

**If hemodynamically stable:**

**For narrow complex, probable supraventricular tachycardia, or regular wide complex tachycardia (monomorphic QRS ONLY):**
- Adenosine 0.1 mg/kg IV not to exceed 6 mg (first dose).
  - May repeat once at 0.2 mg/kg IV not to exceed 12 mg (subsequent dose).

**For wide complex:**
- Contact online Medical Control for consideration of amiodarone 5 mg/kg IV (maximum: 300 mg) over 20-60 minutes.

*For IN administration of midazolam use a 5 mg/mL concentration.*

**PEARLS:**
- Consider and treat potential underlying causes, e.g., hypoxemia, dehydration, fever.
- Signs and symptoms of hemodynamic instability:
  - Hypotension
  - Acutely altered mental status
  - Signs of shock
- **Probable Sinus Tachycardia:**
  - Compatible history consistent with known cause
  - P waves are present and normal
  - Variable R-R and constant P-R interval
  - Infants: rate usually <220/min
  - Children: rate usually <180/min
- **Probable Supraventricular Tachycardia:**
  - Compatible history (vague, nonspecific); history of abrupt onset / rate changes
  - P waves absent / abnormal
  - Heart-rate is NOT variable
  - Infants: rate usually >220/min
  - Children: rate usually >180/min
  - Adenosine should be administered rapidly though a proximal (e.g., antecubital) vein site followed by a rapid saline flush