Thomas Jefferson EMS Council
Regional Spinal Immobilization Guideline

Immobilization NOT required	Full Immobilization
Transport in position of comfort	
Ambulatory at scene after fall/MVC without acute neurologic symptoms. Direct patient to stretcher.	Multi-system blunt trauma (meets CDC triage level 1 or UVA Alpha or Beta alert criteria)
Ground level falls with hip/lower extremity injury, NO acute neurologic symptoms or acute spine pain.	Acutely abnormal mental status due to trauma
Seizure and ground level fall	Acute neurologic symptoms due to blunt trauma, including weakness, numbness, and tingling.
Awake and alert after MVC, in the vehicle, with NO neurologic symptoms, should be allowed the opportunity to self-extricate. Stop if patient complains of pain that limits motion or develops neurologic symptoms.	
NO “standing take down” of ambulatory patients.	

Other considerations:

- Patients should not be forced or “wrestled” into immobilization, transport in position of comfort acceptable to patient. Make the immobilization conform to the patient, not the patient to the immobilization.
- If immobilization procedures/devices worsen or cause symptoms, including pain, neurologic symptoms including numbness, weakness, tingling, or respiratory distress then discontinue procedure/device that aggravated the symptoms.
- Penetrating trauma to head, neck, torso should not be immobilized
    - Manage acute life threats and emphasize prompt transport
- Consider removing spider straps, blocks/rolls, and long backboard after patient has been transferred to ED stretcher when the backboard is used as a transportation device.
- In awake and alert patients, “distracting” injuries do not necessarily preclude an accurate examination or require full immobilization.