

SNHD PARAMEDIC PROTOCOLS PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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1. For unstable tachycardia wide complex VT suspected to be torsades de pointes (polymorphic VT), what is the appropriate action?
 - A. Magnesium sulfate 2 g IV/IO in 50 mL NS over 10 min
 - B. Defibrillate & consider sedation ETOMIDATE 0.15 mg/kg IV/IO
 - C. Repeat defibrillation; assess need for repeat sedation
 - D. Synchronized Cardioversion
2. Which of the following is an early intubation indication in burn patients?
 - A. Extensive deep facial burns
 - B. Burns in mouth
 - C. Signs of airway obstruction
 - D. Total BSA 40%+
3. What is the maximum dose for the first adenosine administration in the stable narrow complex tachycardia protocol?
 - A. 3 mg
 - B. 9 mg
 - C. 6 mg
 - D. 12 mg
4. How is hydroxocobalamin administered in smoke inhalation treatment?
 - A. 5 g IV over 15 minutes
 - B. 5 g IM
 - C. 500 mg IV over 60 minutes
 - D. 1 g IV bolus
5. Which of the following are the two conclusive signs of death?
 - A. Dependent lividity and Rigor mortis
 - B. Dependent lividity only
 - C. Rigor mortis only
 - D. None of the above

- 6. What is the maximum dose of diphenhydramine?**
- A. 25 mg
 - B. 50 mg
 - C. 75 mg
 - D. 100 mg
- 7. Which option is NOT listed as an antidote/reversal agent in the overdose/poisoning protocol?**
- A. Naloxone
 - B. Epinephrine
 - C. Hydroxocobalamin
 - D. Diphenhydramine
- 8. Which statement correctly identifies a contraindication to NIPPV?**
- A. Apnea
 - B. SpO2 97%
 - C. RR 22 per minute
 - D. Retractions or accessory muscle use
- 9. In the MOANS mnemonic, what does O stand for?**
- A. Obese or late pregnancy
 - B. Obstruction
 - C. Oral injury
 - D. Osmolarity
- 10. What is the initial fluid bolus dose for suspected sepsis?**
- A. NS or LR bolus 500 mL IV/IO, reassess criteria and re-examine. May repeat x3 for SBP <90, with no rales on lung exam. Max dose 2000 mL
 - B. 250 mL
 - C. 750 mL
 - D. 1000 mL

Answers

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1. B
2. C
3. C
4. A
5. A
6. B
7. B
8. A
9. A
10. A

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Explanations

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1. For unstable tachycardia wide complex VT suspected to be torsades de pointes (polymorphic VT), what is the appropriate action?

- A. Magnesium sulfate 2 g IV/IO in 50 mL NS over 10 min
- B. Defibrillate & consider sedation ETOMIDATE 0.15 mg/kg IV/IO**
- C. Repeat defibrillation; assess need for repeat sedation
- D. Synchronized Cardioversion

When a wide-complex tachycardia is unstable and torsades de pointes is suspected, the immediate goal is to rapidly terminate the dangerous rhythm to restore perfusion. Delivering a defibrillating shock provides the fastest way to stop the chaotic electrical activity and reset the heart, which is crucial in a hemodynamically compromised patient. Sedation with etomidate can be considered to facilitate the procedure and ensure the patient tolerates it (or to enable a controlled cardioversion if needed), with the dosing typically around 0.15 mg/kg IV/IO. After the rhythm is acutely interrupted, you would address contributing factors and consider magnesium as part of the longer-term management of torsades.

2. Which of the following is an early intubation indication in burn patients?

- A. Extensive deep facial burns
- B. Burns in mouth
- C. Signs of airway obstruction**
- D. Total BSA 40%+

Airway edema from burn injuries can progress rapidly, so securing the airway early when trouble is indicated is key. The clearest signal that an airway needs immediate protection is signs that the airway is becoming obstructed. If a patient exhibits stridor, significant hoarseness or voice changes, use of accessory muscles, or other signs of evolving obstruction, intubation should be performed promptly while the airway is still manageable. This proactive approach prevents a potential airway collapse and hypoxia that can occur if you wait for full obstruction to develop. While extensive facial burns or burns inside the mouth raise concern for possible airway swelling and necessitate careful monitoring and early planning, they do not by themselves prove that obstruction is present. A very large burn surface area indicates severity but does not directly indicate airway status. The key factor guiding early intubation is actual or imminent airway obstruction.

3. What is the maximum dose for the first adenosine administration in the stable narrow complex tachycardia protocol?

- A. 3 mg
- B. 9 mg
- C. 6 mg**
- D. 12 mg

Adenosine is used in stable narrow complex tachycardia to transiently block AV nodal conduction and interrupt AV-nodal dependent reentrant circuits, delivering rapid, short-lived effects that help reveal or terminate the rhythm. Because it acts very quickly and has a short half-life, dosing starts low and is given as a rapid IV push with a saline flush to ensure it reaches the heart promptly. The standard starting dose is 6 mg, and this is the maximum for the first administration. If there's no response after a short interval, a second dose of 12 mg can be given, and sometimes a third 12 mg dose may be used, but the initial dose remains 6 mg to balance effectiveness with safety.

4. How is hydroxocobalamin administered in smoke inhalation treatment?

- A. 5 g IV over 15 minutes
- B. 5 g IM
- C. 500 mg IV over 60 minutes
- D. 1 g IV bolus

When cyanide poisoning from smoke inhalation is suspected, hydroxocobalamin is given IV to bind cyanide quickly. The standard emergent dose is 5 g administered over about 15 minutes, providing rapid cyanide sequestration so tissues can resume oxygen use. Intravenous delivery ensures fast onset; administering by intramuscular route would delay absorption and delay treatment. The other dosing options are not appropriate because they are either far too small or not delivered in a way that achieves rapid, sufficient cyanide binding. A 5 g IV dose over 15 minutes is the widely accepted approach, with a second dose sometimes considered per local protocols if needed.

5. Which of the following are the two conclusive signs of death?

- A. Dependent lividity and Rigor mortis
- B. Dependent lividity only
- C. Rigor mortis only
- D. None of the above

Death pronouncement in the field relies on postmortem changes that prove circulation and metabolism have ceased. The two conclusive signs are dependent lividity and rigor mortis. Dependent lividity is the pooling of blood in the lowest parts of the body after circulation stops, producing a characteristic purplish discoloration. Rigor mortis is the progressive stiffening of muscles due to chemical changes in the muscles after death, beginning a few hours after death and reaching full rigidity within hours. When both signs are present, they together confirm that death has occurred, since they reflect ongoing cessation of circulation and metabolic processes beyond reversible states. One sign alone is not definitive, and timing can vary with temperature and other factors, but the combination of dependent lividity and rigor mortis is the best indicator in the field.

6. What is the maximum dose of diphenhydramine?

- A. 25 mg
- B. 50 mg
- C. 75 mg
- D. 100 mg

Diphenhydramine is given in EMS as an adjunct for allergic reactions, and the dose is limited per administration to balance benefit with potential anticholinergic and sedative side effects. In typical paramedic protocols, the maximum single dose is 50 mg, given by IM or IV. Doses of 50 mg provide the needed antihistamine effect without a disproportionate jump in adverse effects; increasing beyond 50 mg raises risks such as excessive drowsiness, confusion, urinary retention, tachycardia, and hypotension, with limited added therapeutic benefit in the acute prehospital setting. Therefore, 50 mg per dose is the appropriate maximum. Smaller doses (like 25 mg) may be used for sensitivity or pediatrics, but 50 mg remains the per-dose ceiling.

7. Which option is NOT listed as an antidote/reversal agent in the overdose/poisoning protocol?

- A. Naloxone
- B. Epinephrine**
- C. Hydroxocobalamin
- D. Diphenhydramine

In overdose/poisoning protocols, antidotes or reversal agents are substances that directly counteract a specific toxin's effect. Naloxone reverses opioid toxicity by displacing opioids from receptor sites, restoring respiration. Hydroxocobalamin binds cyanide to form a safely excreted compound, countering cyanide poisoning. Diphenhydramine isn't an antidote to a particular toxin; it's an antihistamine that may be involved in general symptom management but does not reverse a specific poisoning mechanism. Epinephrine, while crucial in treating life-threatening allergic reactions and used as a vasopressor in certain toxin-induced shocks, is not an antidote that neutralizes a poison. Therefore, epinephrine is not listed as an antidote/reversal agent in the overdose/poisoning protocol.

8. Which statement correctly identifies a contraindication to NIPPV?

- A. Apnea**
- B. SpO2 97%
- C. RR 22 per minute
- D. Retractions or accessory muscle use

Noninvasive ventilation relies on the patient's own breathing to deliver breaths through a mask. It also depends on the ability to protect the airway. If the patient is apneic, there's no respiratory effort to augment, so the mask cannot provide effective ventilation and airway protection is lost. Using NIPPV in this situation can lead to worsening ventilation failure and increased risk of aspiration, making apnea a true contraindication. SpO2 of 97% shows good oxygenation and isn't a contraindication. A respiratory rate of 22 per minute indicates some tachypnea but isn't by itself a disqualifier if the patient can still breathe adequately and protect the airway. Retractions or use of accessory muscles signal increased work of breathing, but they're not an absolute contraindication; many patients can still be treated with NIPPV if they're cooperative and able to maintain airway patency.

9. In the MOANS mnemonic, what does O stand for?

- A. Obese or late pregnancy**
- B. Obstruction
- C. Oral injury
- D. Osmolarity

O stands for obesity or late pregnancy. This factor flags potential difficulty with airway management because both conditions reduce how easily you can ventilate and intubate. Obesity lowers functional residual capacity, increases oxygen demand, and can make mask sealing harder due to facial adiposity, leading to faster desaturation if you're not well preoxygenated. Late pregnancy also lowers lung volumes as the enlarged uterus pushes up on the diaphragm, adds airway edema from hormonal changes, and increases the risk of aspiration. So when O is present, you plan for a potentially difficult airway: ensure thorough preoxygenation, be prepared for rapid sequence intubation if appropriate, and have alternative airway devices and suction ready. The other options don't capture these predictive airway challenges: obstruction refers to a blockage, oral injury to trauma of the mouth, and osmolarity is not related to airway management.

10. What is the initial fluid bolus dose for suspected sepsis?

- A. NS or LR bolus 500 mL IV/IO, reassess criteria and re-examine. May repeat x3 for SBP <90, with no rales on lung exam. Max dose 2000 mL**
- B. 250 mL
- C. 750 mL
- D. 1000 mL

In suspected sepsis, fluids are started in moderate, titratable steps using 500 mL boluses of isotonic crystalloid (normal saline or lactated Ringer's) given IV or IO, with reassessment after each dose. This approach lets you quickly evaluate how the patient responds and adjust without overloading the circulation. If the patient's systolic blood pressure remains under 90 mmHg and there are no signs of fluid overload such as rales on lung exam, you may repeat the 500 mL bolus up to three times, for a total maximum of 2000 mL. If rales are present, that indicates possible pulmonary edema, and further fluid boluses should be avoided. The key is to balance restoring perfusion with careful monitoring and timely reassessment after each increment.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://snhdparamedicprotocol.examzify.com>

We wish you the very best on your exam journey. You've got this!

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