



OVERDOSE REVERSAL AND NALOXONE ADMINISTRATION REPORTING FORM

THIS FORM IS TO BE COMPLETED WITHIN FIVE (5) BUSINESS DAYS OF NALOXONE ADMINISTRATION

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Agency Name:	Date/Time:
Name of Staff Who Administered Naloxone:	Additional Staff:

Use of Naloxone During Emergency Drug Overdose				
How many doses of naloxone did you use?	How was naloxone given?	Lot Number		
Date naloxone was used (MM/DD/YY):	Has patient been treated with naloxone in the past by PD?	Yes	No	Unknown
	If yes, how many times?	Unknown		

Location of Use/Location of Overdose	
Municipality:	Was this location?

About the Overdoser/Is the Overdoser? (Check all that apply)		
Male	Unknown Sex	
Female	About how old is the overdoser? (Use your best guess)	Years old

Is the Overdoser (Check all that apply)			
African-American/Black	Hispanic/Latino(s)	Caucasian/White	Unknown
Asian/Pacific Islander	Native American	Other Race/Ethnicity	Please Specify:

What Drugs Had Been Used/Did the Overdoser (Check all that apply)					Inject Heroin	Sniff Heroin
Methadone	Amphetamine	Alcohol	Unknown	Use Heroin, But How is Unknown		
Pain Pills	Cocaine	Benzos	Other Drugs	Please Specify:		

Condition of Overdoser				
Was overdoser conscious before naloxone was used?	Yes	No	Unknown	

Actions Taken				
Was rescue breathing performed?	Yes	No	Unknown	
Did Emergency Medical Services assist in overdose?	Yes	No	Unknown	

Outcome						
Victims Response to Naloxone	Did the overdose victim survive?			Yes	No	Unknown

Other Information	Was the overdoser given a Resource Card?	Yes	No
Please provide any information that would be helpful in describing the overdose:			