

Overdose Prevention Program Report-Back Form

Date: / / Staff ID: _____ Department: _____

Reason for refill: Administered kit Broken/lost kit Kit outdated Other _____

If kit used for overdose, please complete the rest of the form.

Date of Overdose: / / Time of Overdose: _____ : _____ AM PM (circle one)

ZIP code where overdose occurred:

Gender of the person who overdosed?
 Female Male Unknown

Signs of overdose present: *(check all that apply)*

Unresponsive Breathing slowly Not breathing Blue lips
 Slow pulse No pulse Other (specify) _____

Overdosed on what drugs? *(check all that apply)*

Heroin Benzos/Barbituates Cocaine/Crack Suboxone Any other opioid
 Alcohol Methadone Don't Know Other (specify) _____

Was naloxone given during overdose?

Yes No Don't know

↳ If YES, number of doses used: |__| |__|

↳ If YES, did it work? **(If pilot program naloxone was not given or did not work, please explain in comments)**

Yes No Not sure

↳ If pilot program naloxone worked, how long did it take to work?

Less than 1 min 1-3 min 3-5 min >5 min Don't Know

↳ Response to naloxone: *(check one)*

Responsive and alert Responsive but sedated No response to naloxone

↳ Post-naloxone withdrawal symptoms: *(check all that apply)*

None Dope Sick (e.g. nauseated, muscle aches, runny nose, and/or watery eyes)
 Irritable or Angry Physically Combative Vomiting Other (specify): _____

Was the person alive the last time you observed them? Yes No Not Sure

What else was done? *(check all that apply)*

Sternal rub / Lip rub Recovery Position Rescue breathing Chest Compressions
 Automatic Defibrillator Yelled Shook them Oxygen
 EMS naloxone Other (specify): _____

Disposition: *(check one)*

Care transferred to EMS Other (specify): _____

Notes / Comments