Printable Form

Illinois Department of Human Services - Division of Alcoholism and Substance Abuse

OVERDOSE REVERSAL AND NALOXONE ADMINISTRATION REPORTING FORM

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

Program Name: _____ Site Name: _____ Date Completing Form: _____

Responder's Name: _____ Or Code Identifier: (if applicable) _____ 1st Responder ☑ Bystander/ Outreach ☐

Location of Use/Location of Overdose

Closest Cross Streets: _____ City/Town/Community _____

County: _____ Zip code: _____

Location: ☐ Apartment ☐ Motel ☐ Shelter ☐ Business ☐ Parking lot ☐ Vehicle ☐ Train ☐ Park

☐ House ☐ School ☐ Jail ☐ Other: _____

About the Person: **Fill in answers to the best of your knowledge:**

☐ Male ☐ Female ☐ Transgender ☐ Other _____ Age: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino

Race: ☐ African American/Black ☐ Native American ☐ Unknown

☐ Caucasian/White ☐ Asian/Pacific Islander ☐ Other Race/Ethnicity Please Specify: _____

Specific Drugs Used:

(Check all that apply)

☐ Heroin If (YES), Please specify Method: ☐ *Injection* ☐ *Sniff* ☐ *Swallow* ☐ *Smoke* ☐ *Unknown*

☐ Fentanyl ☐ Methadone ☐ Cocaine ☐ Benzodiazepine ☐ Cannabis ☐ Alcohol ☐ Opiate Pain medication (Specify if Known) _____

List Other Drugs/ Medications ☐ _____

Condition of Person:

1. Was the person conscious before naloxone was used? ☐ Yes ☐ No
2. How was naloxone administered? ☐ Injected in the muscle ☐ Sprayed in the nose
3. How many doses of naloxone were used? ☐ One ☐ Two ☐ More than 2 (Please Specify): _____
4. Other Actions Taken: (Check all that apply) ☐ Rescue Breathing ☐ Chest Compressions ☐ Sternal Rub ☐ Recovery Position ☐ Called 911
5. Did the person go to the hospital? ☐ Yes ☐ No ☐ Refused If Yes, list name of hospital if known: _____
6. Did the person survive? ☐ Yes ☐ No ☐ Unknown 7. Date naloxone was administered: _____
8. Was naloxone ever received in the past? ☐ Yes ☐ No ☐ Unknown

Please provide any additional information:

_____

_____

Name and Signature of Program Director and Health Care Professional

_____ Program Director Name

_____ Program Director Signature

_____ Date

_____ Health Care Professional Signature

_____ Health Care Professional Signature

_____ Date

IL 444-2053 (R-11-16)

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This form is to be submitted through the Jotform Re-supply Request Form

For questions, contact DNP@dupagehealth.org