

NYSDOH Opioid Overdose Prevention Initiative

Community Naloxone Usage Form



Purpose: This form is to serve as a collection tool for program staff. Program staff are required to enter the information into the NYSDOH Opioid Overdose Prevention Program System's electronic DOH sanctioned form.

On what day was the naloxone used?

Date naloxone used:

If naloxone was used on more than one day, please submit a separate report for each use. If you don't know the precise date, choose one that you think is close.

Yes: Zip Code:

Do you know the zip code where the overdose happened?

No: County/Borough & Town

Outside NYS

Did the person who overdosed survive? (choose one)

Yes

No

Don't know

(Check all that apply.) Select the type of naloxone used and the number of doses given.

Narcan™ Nasal spray, Doses:

- 1
- 2
- 3
- 4
- More than 4
- Don't Recall



Intramuscular injection generic Doses:

- 1
- 2
- 3
- 4
- More than 4
- Don't Recall



Nasal spray generic Doses:

- 1
- 2
- 3
- 4
- More than 4
- Don't Recall



Evzio Autoinjector Doses:

- 1
- 2
- 3
- 4
- More than 4
- Don't Recall



Did anyone else also give naloxone for this same overdose? (choose one)

Yes

No

Don't know

(check all that apply) Were they

- Police
- EMS
- Fire Fighter

- Another civilian witness or bystander
- Other

Do you know what type of naloxone they used?

Yes

No

(Check all that apply) What did they use (formulation & doses)?

Narcan™ Nasal spray doses:

- 1
- 2
- 3
- 4
- More than 4
- Don't Recall



Intramuscular injection generic doses:

- 1
- 2
- 3
- 4
- More than 4
- Don't Recall



Nasal spray generic doses:

- 1
- 2
- 3
- 4
- More than 4
- Don't Recall



Evzio Autoinjector doses:

- 1
- 2 3
- 4
- More than 4
- Don't Recall



Other

Was 911 called? (choose one)

Yes

No

Don't know

Was rescue breathing performed before EMS, police or fire fighters arrived? (choose one)

Yes

No

Don't know

Were chest compressions performed before EMS, police or fire fighters arrived? (choose one)	Yes	No	Don't know
How old were they? (best guess)	Age:		
Were they	<input type="checkbox"/> Male	<input type="checkbox"/> Transgender or gender non-conforming	
	<input type="checkbox"/> Female	<input type="checkbox"/> Unknown Sex	
		<input type="checkbox"/> Other	
Were they (more than one may be selected)	<input type="checkbox"/> African-American/Black	<input type="checkbox"/> Native American	
	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> White	
	<input type="checkbox"/> Hispanic/Latino(a)	<input type="checkbox"/> Unknown race/ethnicity	
		<input type="checkbox"/> Other	
(Indicate all that apply) Select which drugs the overdoser is likely to have used.	<input type="checkbox"/> Heroin	<input type="checkbox"/> Alcohol	
	<input type="checkbox"/> Pain pills	<input type="checkbox"/> Amphetamine/methamphetamine	
	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Methadone	
	<input type="checkbox"/> Fentanyl	<input type="checkbox"/> Don't know	
	<input type="checkbox"/> Benzos	<input type="checkbox"/> Other	
In what kind of place did the overdose happen?			
<input type="checkbox"/> Someone's home or apartment		<input type="checkbox"/> Library	
<input type="checkbox"/> Shelter or in a supportive housing setting		<input type="checkbox"/> Secondary school (e.g. high school, middle school)	
<input type="checkbox"/> Agency or facility that provides services, such as a syringe exchange, drug treatment program or social services agency or government office		<input type="checkbox"/> On a college/university/trade school campus	
<input type="checkbox"/> Public place <u>outside</u> (e.g. park; sidewalk, yard)		<input type="checkbox"/> Other	
<input type="checkbox"/> Public place <u>inside</u> , other than a library, secondary school, or college/university/trade school campus (e.g. restroom, business, train, car)			
What is the relationship between the person who overdosed and the responder?	<input type="checkbox"/> Friend or acquaintance	<input type="checkbox"/> Patient or client	<input type="checkbox"/> Prefer not to answer
	<input type="checkbox"/> Family	<input type="checkbox"/> Don't know	
	<input type="checkbox"/> Stranger	<input type="checkbox"/> Other (specify)	
Has this person experienced an opioid overdose in the past? (choose one)	Yes	No	Don't know
Was a replacement kit given? (choose one)	Yes	No	Don't know
Was information provided about getting naloxone from a pharmacy? (choose one)	Yes	No	Don't know
Please add any additional comments about this naloxone administration.	Comment:		

Thank you for taking the time to complete this form. All program data submitted are confidential.
If you have any questions, please email overdose@health.ny.gov or call 1.800.692.8528

For Registered Program Internal Use (optional): If your program collects additional information about the administration of naloxone, you may enter that here.

***DO NOT* provide any patient- or client-specific information on this form.**