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?
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.

Date naloxone used:

Do you know the zip code where the overdose happened?

Yes: Zip Code:

No: County/Borough & Town

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 <u>they</u> 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

If you have any questions, please email overdose@health.ny.gov or call 1.800.692.8528

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	☐ Male ☐ Female	☐ Transgendered or gender non-conforming ☐ Unknown Sex ☐ Other	
Were they (more than one may be selected)	☐ African-American/Black ☐ Asian/Pacific Islander ☐ Hispanic/Latino(a)	☐ Native American ☐ White ☐ Unknown race/ethnicity ☐ Other	
(Indicate all that apply) Select which drugs the overdoser is likely to have used.	☐ Heroin ☐ Pain pills ☐ Cocaine ☐ Fentanyl ☐ Benzos	☐ Alcohol ☐ Amphetamine/methamphetamine ☐ Methadone ☐ Other	

In what kind of place did the overdose happen?

- ☐ Someone's home or apartment
- ☐ Shelter or in a supportive housing setting
- ☐ Agency or facility that provides services, such as a syringe exchange, drug treatment program or social services agency or government office
- ☐ Public place outside (e.g. park; sidewalk, yard)
- ☐ Public place inside, other than a library, secondary school, or college/university/trade school camp us (e.g. restroom, business, train, car)
- ☐ Library
- ☐ Secondary school (e.g. high school, middle school)
- ☐ On a college/university/trade school campus
- ☐ Other

What is the relationship to the person who overdosed?	☐ Friend or acquaintance ☐ Family ☐ Stranger	☐ Patient or client Prefer not to answer ☐ 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

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.**