

# New York State Public Safety Naloxone Quality Improvement Usage Report

Version: 3/10/2015

**Date of Overdose:** / /   :  :   AM  PM

**Arrival Time of Responder:**  :   AM  PM

**Arrival Time of EMS:**  :   AM  PM

Agency Case #:  Gender of the Person Who Overdosed:  Female  Male  Unknown Age:

ZIP Code Where Overdose Occurred:  County Where Overdose Occurred:

**Aided Status Prior to Administering Naloxone:** (Check one in each section.)

**Responsiveness:**  Unresponsive  Responsive but Sedated  Alert and Responsive  Other (specify):

**Breathing:**  Breathing Fast  Breathing Slow  Breathing Normally  Not Breathing

**Pulse:**  Fast Pulse  Slow Pulse  Normal Pulse  No Pulse  Did not Check Pulse

**Aided Overdosed on What Drugs:** (Check all that apply.)

Heroin  Benzos/Barbiturates  Cocaine/Crack  Buprenorphine/Suboxone  Pain Pills  Unknown Pills

Unknown Injection  Alcohol  Methadone  Don't Know  Other (specify):

**Administration of Naloxone** Number of naloxone vials used:  1 vial  2 vials  3 vials  4 vials  > 4 vials

**How long did 1st dose of naloxone take to work:**  < 1 minute  1-3 minutes  4-5 minutes  > 5 minutes  Don't Know  Didn't Work

**Aided's response:**  Combative  Responsive & Angry  Responsive & Alert  Responsive but Sedated  Unresponsive but Breathing  No Response

**If 2nd dose given, was it:**  IN (intranasal)  IM (intramuscular)  IV (intravenous)

**How long after 1st dose was 2nd dose administered:**  < 1 minute  1-3 minutes  4-5 minutes  > 5 minutes  Don't Know

**Aided's response:**  Combative  Responsive & Angry  Responsive & Alert  Responsive but Sedated  Unresponsive but Breathing  No Response

**Post-naloxone symptoms:** (Check all that apply.)

None  Dope Sick (e.g. nauseated, muscle aches, runny nose and/or watery eyes)  Respiratory Distress

Seizure  Vomiting  Other (specify):

**What Else was Done by the Responder:** (Check all that apply.)

Yelled  Shook Them  Sternal Rub  Recovery Position  Bag Valve Mask  Mouth to Mask  Mouth to Mouth

Defibrillator (if checked, indicate status of shock):  Defibrillator - no shock  Defibrillator - shock administered

Chest Compressions  Oxygen  Other (specify):

**Was Naloxone Administered by Anyone Else at the Scene:** (Check all that apply.)

EMS  Bystander  Other (specify):

**Disposition:** (Check one.)  Transported by EMS  EMS Transport Refused  Other (specify):

**Did the Person Live:**  Yes  No  Don't Know

**Hospital Destination:**  **Transporting Ambulance:**

**Comments:**

**Administering Responder's Information:** Agency:   Police  Fire  EMS Badge #:

Last Name:  First Name:

Please send the completed form to the NYS Department of Health using any one of the three following methods:

E-mail: stems@sthcs.org  
Fax: (716) 372-5217

Mail: Southern Tier Health Care System, Inc. - STEMS  
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Olean, New York 14760