

New York State Department of Health Opioid Overdose Reporting Form

Program name:	Site name:	Today's Date (MM/DD/YY):
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A. Reason For Visit / Naloxone Refill

1. Was your naloxone (Check one only)	<input type="checkbox"/> Used? <input type="checkbox"/> Past expiration date?	<input type="checkbox"/> Lost? <input type="checkbox"/> Never received?	<input type="checkbox"/> Taken by police? <input type="checkbox"/> Other → Please specify:
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B. Use of Naloxone

2a. How many doses of naloxone did you use? (Check one only)	<input type="checkbox"/> None (If naloxone was not used to reverse an overdose, form ends here.) <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Two or more <input type="checkbox"/> Unknown
2b. How was naloxone given? (Check one only)	<input type="checkbox"/> Injected in the muscle <input type="checkbox"/> Sprayed in the nose <input type="checkbox"/> Unknown
3. Date naloxone was used: (MM/DD/YY):	(If exact day is unknown, please provide month ____ and year ____.)

C. Location of Use

4. Location of overdose:	Borough/County:	Neighborhood:	Zip code:
5. Was this location: (Check one only)	<input type="checkbox"/> A house / an apartment? <input type="checkbox"/> A business (e.g. store, bar, restaurant)? <input type="checkbox"/> Unknown?	<input type="checkbox"/> On the street / outside? <input type="checkbox"/> An SRO? <input type="checkbox"/> Other → Please specify:	<input type="checkbox"/> A shooting gallery? <input type="checkbox"/> A shelter?

D. About the Overdoser

6. Were they (Check all that apply)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Transgender <input type="checkbox"/> Intersex	<input type="checkbox"/> Unknown sex <input type="checkbox"/> Other → Please specify:
7. Were they (Check all that apply)	<input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other race/ethnicity → please specify:	<input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Native American	<input type="checkbox"/> Caucasian/White <input type="checkbox"/> Unknown
8. About how old were they? (Use your best guess) ____ years old			

E. What Drugs Had Been Used

9. Did the overdoser: (Check one only)	<input type="checkbox"/> Inject heroin <input type="checkbox"/> Not use heroin	<input type="checkbox"/> Sniff heroin <input type="checkbox"/> Not sure if heroin was used	<input type="checkbox"/> Use heroin, but how is unknown
10. Was the overdoser using anything else? (Check all that apply)	<input type="checkbox"/> Methadone <input type="checkbox"/> Pain pills <input type="checkbox"/> Amphetamine	<input type="checkbox"/> Cocaine <input type="checkbox"/> Alcohol <input type="checkbox"/> Other drugs → please specify:	<input type="checkbox"/> Benzos <input type="checkbox"/> Unknown

F. Condition of Overdoser

11. Was overdoser conscious before naloxone was used?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
12. Was overdoser breathing before naloxone was used?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

G. Actions Taken

13. Was rescue breathing performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
14. Were EMS (911) contacted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

H. Outcome

15. Did the overdose survive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
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I. Other Information

16. Please provide any information that would be helpful in describing the overdose:
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J. Signatures of Program Director and Clinical Director

_____ Program Director	_____ Date (MM/DD/YY)	_____ Clinical Director	_____ Date (MM/DD/YY)
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Please send the completed form using any one of the three methods below:

E-mail: oper@health.state.ny.us	Fax: (518) 402-6813	Shu-Yin John Leung OPER, AIDS Institute, NYSDOH Empire State Plaza CR342 Albany, New York 12237
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