State of Illinois
Department of Human Services - Division Substance Abuse Prevention and Recovery

OVERDOSE REVERSAL AND NALOXONE ADMINISTRATION REPORTING FORM

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

Responder Name (or Code Identifier): _____ Check one:1st Responder ☐ Bystander/Outreach ☐

City/Town: _____ Zip Code: _____ Closest Cross Streets: _____ / _____ County: _____

Date Naloxone was used: _____

Location of Naloxone Administration:

- ☐ Home/Residence (includes house, apartment, condominium)
- ☐ Other Residence (School Residence Hall, Nursing Home, Military Base, Prison/Jail, Recovery Home, In-patient Treatment Facility, Hotel/Motel/SRO)
- ☐ Public Building Site (Church, School, Courthouse, Library)
- ☐ Business Site (Restaurant, Store/Mall, Train/Bus Station, Rest Stop/Gas Station - Includes Public Bathroom)
- ☐ Public Outdoor Site (Street/Park/Lots/Vehicles/Public Transportation Platforms)
- ☐ Other Please Specify: _____

Condition of Person:

Did the person survive? Yes ☐ No ☐ Unknown ☐

Naloxone Type: ☐ Nasal ☐ Muscle Injection ☐ IV Push

Dosage Needed: ☐ Single Dose ☐ Multiple Doses

Was the person conscious before Naloxone was used? Yes ☐ No ☐ Unknown ☐

Other Actions Taken: ☐ None ☐ Called 911 ☐ Rescue Breathing ☐ Chest Compressions ☐ Sternal Rub ☐ Recovery Position

Did the person go to Hospital? Yes ☐ No ☐ Unknown ☐ If yes, Hospital Name (if known): _____

Did this person ever receive Naloxone before? Yes ☐ No ☐ Unknown ☐

About the Person:

Gender: ☐ Male ☐ Female ☐ Trans-gender

Age: ☐ under 18 ☐ 18-24 ☐ 25-44 ☐ 45-64 ☐ 65+ ☐ Unknown

Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unknown

Race: ☐ African-American/Black ☐ Caucasian/White ☐ Asian/Pacific Islander ☐ Native American ☐ Other ☐ Unknown

_____ _____
Program Director's Printed Name and Signature Date

_____ _____
* Health Care Professional's Printed Name and Signature Date

** Not needed if utilizing the statewide standing order)*