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

OVERDOSE REVERSAL AND NALOXONE ADMINISTRATION REPORTING FORM

Program Name: _____ Site Name: _____

Responder Name (or Code Identifier): _____

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

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

Dosage Needed: ☐ Single Dose ☐ Multiple Doses

Was 911 called? Yes ☐ No ☐ Unknown ☐

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

Other Actions Taken:

☐ None ☐ Rescue Breathing ☐ Chest Compressions ☐ Sternal Rub ☐ Recovery Position

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

About the Person:

Gender: ☐ Male ☐ Female ☐ Transgender

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

Race/Ethnicity:

☐ African-American/Black ☐ Caucasian/White ☐ Hispanic/Latino ☐ Asian

☐ Native Hawaiian or Pacific Islander ☐ American Indian ☐ More than one race/ethnicity