Naloxone Administration Form

Please return completed forms to the Cambria County Drug and Alcohol Program
Email: shershberger@co.cambria.pa.us OR Fax: 814-536-6867

AGENCY NAME	AGENCY INCIDENT NUMBER	DATE OF OVERDOSE	TIME OF OVERDOSE ◯ AM ◯ PM

OVERDOSE OCCURRED - *City*	*County*	*Zip Code*	**VICTIM RESIDENCE** - *City*	*State*	*Zip Code*

GENDER OF THE VICTIM	AGE	RACE/ETHNICITY OF THE VICTIM
◯ Male ◯ Female ◯ Unk.		◯ White ◯ Black ◯ Hispanic ◯ Asian/Indian ◯ Native American ◯ Pacific Islander

HAS THE VICTIM RECEIVED NALOXONE IN THE PAST? ◯ Yes ◯ No ◯ Unknown

Suspected Overdose on What Drugs? *(Check all that apply.)*

☐ Heroin ☐ Benzos/Barbituates ☐ Cocaine/Crack ☐ Unknown
☐ Alcohol ☐ Methadone ☐ Suboxone ☐ Other (*specify*) _____

Evidence

☐ Evidence Secured ☐ Drugs ☐ Paraphernalia

☐ Heroin Stamp *(Text/Color)*: _____ Desc. Image: _____
Stamp *(Text/Color)*: _____ Desc. Image: _____

☐ Opiate Pills Pill Type: _____ Dr.'s Name: _____

Details of Naloxone Administration

HOW MANY DOSES DID YOU ADMINISTER?	NUMBER OF DOSES ADMINISTERED BY SOMEONE ELSE *(Enter all that apply.)* EMS____ Other LE____ Bystander____ Other____

HOW LONG DID IT TAKE FOR THE NALOXONE TO WORK?
◯ <1 Min. ◯ 1-3 Min. ◯ 3-5 Min. ◯ >5 Min. ◯ Don't Know ◯ Did Not Work

PERSON'S RESPONSE TO NALOXONE
◯ Responsive and Alert ◯ Combative ◯ Responsive but Sedated ◯ Responsive and Angry ◯ No Response to Naloxone

DID THE PERSON SURVIVE?
◯ Yes ◯ No ◯ Unknown

IF THE VICTIM WAS REVIVED, WHAT HAPPENED NEXT?
◯ Arrest ◯ Hospital ◯ Released Free ◯ Other_____

NALOXONE LOT #	EXPIRATION DATE

Notes/Comments

RESPONDER'S NAME	RESPONDER'S SIGNATURE/DATE	CONTACT PHONE NUMBER