



Illinois Department of Human Services - Division of Alcoholism and Substance Abuse

OVERDOSE REVERSAL AND NALOXONE ADMINISTRATION REPORTING FORM

(THIS FORM IS TO BE COMPLETED WITHIN FIVE (5) BUSINESS DAYS OF NALOXONE ADMINISTRATION)

Program Name: _____ Site Name: _____ Date Completing Form: _____
 Responder's Name: _____ Or Code Identifier: _____ 1st Responder _____ Bystander/
 (if applicable) Outreach _____

Location of Use/Location of Overdose		City/Town/Community						
Closest Cross Streets:		County:				Zip code:		
Location:	Apartment	Motel	Shelter	Business	Parking lot	Vehicle	Train	Park
	House	School	Jail	Other:				

About the Person: Fill in answers to the best of your knowledge:

Male Female Transgender Other Age: _____

Ethnicity: Hispanic/Latino Non Hispanic/Latino

Race: African American/Black Native American Unknown
 Caucasian/White Asian/Pacific Islander Other Race/Ethnicity Please Specify: _____

Specific Drugs Used: Heroin If (YES), Please specify Method: *Injection Sniff Swallow Smoke Unknown*

(Check all that apply)

Fentanyl Methadone Cocaine Benzodiazepine Cannabis Alcohol Opiate Pain medication (Specify if Known)

List Other Drugs/ Medications _____

Condition of Person:

1. Was the person conscious before naloxone was used? Yes No

2. How was naloxone administered? Injected in the muscle Sprayed in the nose

3. How many doses of naloxone were used? One Two More than 2 (Please Specify): _____

4. Other Actions Taken: Rescue Breathing Chest Compressions Sternal Rub Recovery Position Called 911
 (Check all that apply)

5. Did the person go to the hospital? Yes No Refused If Yes, list name of hospital if known: _____

6. Did the person survive? Yes No Unknown 7. Date naloxone was administered: _____

8. Was naloxone ever received in the past? Yes No Unknown

Please provide any additional information:

Name and Signature of Program Director and Health Care Professional

Program Director Name _____ Program Director Signature _____ Date _____

Health Care Professional Signature _____ Health Care Professional Signature _____ Date _____