Iowa Department of Public Safety
Naloxone Administration Report

Case Number:

Date of Overdose:

Arrival Time of Employee:

Arrival Time of EMS:

Gender: ☐ Male ☐ Female Age: Race:

First Name: Last Name:

Address: County:

Where did the overdose occur?

☐ Private Residence ☐ Street ☐ Hotel / Motel

☐ Other:

Overdosed on what suspected drug:

How did you know that an overdose was happening? (Check all that apply.)

☐ Person looked blue
☐ Person wouldn't wake up
☐ Person stopped breathing
☐ No response to sternal rub or painful stimuli
☐ Advised by witness at scene

Administration of Naloxone

Was Naloxone administered: ☐ Yes ☐ No

Number of vials used?

Total Mgs administered?

Serial Number of Naloxone used?

Did Naloxone work? ☐ Yes ☐ No

Was Naloxone administered by anyone else at the scene?

☐ EMS
☐ Bystander
☐ Other:

Response to Naloxone

Did the person experience any of the following?

- ☐ None
- ☐ Seizure
- ☐ Vomiting
- ☐ Respiratory Distress
- ☐ Experience any symptoms of withdrawal? ☐ None ☐ Mild ☐ Severe
- ☐ Display any agression because of these symptoms? ☐ Yes ☐ No

Approximately how long did it take for the Naloxone to work?

Did the person live? ☐ Yes ☐ No

Hospital Destination:

Was paraphernalia and/or evidence present to support an overdose? ☐ Yes ☐ No

Were there witnesses to the overdose? ☐ Yes ☐ No

If Yes, obtain information to the overdose and ID data.

Administering Employee Information

Division: **Select One:**

Name:

This form must be completed within 24 hours of administration and submitted to your immediate supervisor. The supervisor must submit this form to the Naloxone Agency Coordinator (Asst. Director - DNE) within 72 hours.

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