# New York State Department of Health Opioid Overdose Reporting Form

| Program name: | Site name: | Today's Date (MM/DD/YY): |
|---|---|---|

**A. Reason For Visit / Naloxone Refill**

| | | | |
|---|---|---|---|
| 1. Was your naloxone (*Check one only*) | ☐ Used? | ☐ Lost? | ☐ Taken by police? |
| | ☐ Past expiration date? | ☐ Never received? | ☐ Other → Please specify: |

**B. Use of Naloxone**

| | | | | |
|---|---|---|---|---|
| 2a. How many doses of naloxone did you use? (*Check one only*) | ☐ None (*If naloxone was not used to reverse an overdose, form ends here.*) | | | |
| | ☐ One | ☐ Two | ☐ Two or more | ☐ Unknown |
| 2b. How was naloxone given? (*Check one only*) | ☐ Injected in the muscle | ☐ Sprayed in the nose | ☐ Unknown | |
| 3. Date naloxone was used: (MM/DD/YY): | (*If exact day is unknown, please provide month* _____ *and year* _____.) | | | |

**C. Location of Use**

| | | | |
|---|---|---|---|
| 4. Location of overdose: | Borough/County: | Neighborhood: | Zip code: |
| 5. Was this location: (*Check one only*) | ☐ A house / an apartment? | ☐ On the street / outside? | ☐ A shooting gallery? |
| | ☐ A business (e.g. store, bar, restaurant)? | ☐ An SRO? | ☐ A shelter? |
| | ☐ Unknown? | ☐ Other → Please specify: | |

**D. About the Overdoser**

| | | | |
|---|---|---|---|
| 6. Were they (*Check all that apply*) | ☐ Male | ☐ Transgender | ☐ Unknown sex |
| | ☐ Female | ☐ Intersex | ☐ Other → Please specify: |
| 7. Were they (*Check all that apply*) | ☐ African-American/Black | ☐ Hispanic/Latino(a) | ☐ Caucasian/White |
| | ☐ Asian/Pacific Islander | ☐ Native American | ☐ Unknown |
| | ☐ Other race/ethnicity → please specify: | | |
| 8. About how old were they? (*Use your best guess*) _____ years old | | | |

**E. What Drugs Had Been Used**

| | | | |
|---|---|---|---|
| 9. Did the overdoser: (*Check one only*) | ☐ Inject heroin | ☐ Sniff heroin | ☐ Use heroin, but how is unknown |
| | ☐ Not use heroin | ☐ Not sure if heroin was used | |
| 10. Was the overdoser using anything else? (*Check all that apply*) | ☐ Methadone | ☐ Cocaine | ☐ Benzos |
| | ☐ Pain pills | ☐ Alcohol | ☐ Unknown |
| | ☐ Amphetamine | ☐ Other drugs → please specify: | |

**F. Condition of Overdoser**

| | | | |
|---|---|---|---|
| 11. Was overdoser conscious before naloxone was used? | ☐ Yes | ☐ No | ☐ Unknown |
| 12. Was overdoser breathing before naloxone was used? | ☐ Yes | ☐ No | ☐ Unknown |

**G. Actions Taken**

| | | | |
|---|---|---|---|
| 13. Was rescue breathing performed? | ☐ Yes | ☐ No | ☐ Unknown |
| 14. Were EMS (911) contacted? | ☐ Yes | ☐ No | ☐ Unknown |

**H. Outcome**

| | | | |
|---|---|---|---|
| 15. Did the overdose survive? | ☐ Yes | ☐ No | ☐ Unknown |

**I. Other Information**

16. Please provide any information that would be helpful in describing the overdose:

**J. Signatures of Program Director and Clinical Director**

| | | | |
|---|---|---|---|
| _____ Program Director | _____ Date (MM/DD/YY) | _____ Clinical Director | _____ Date (MM/DD/YY) |

*Please send the completed form using any one of the three methods below:*

| | | |
|---|---|---|
| E-mail: oper@health.state.ny.us | Fax: (518) 402-6813 | Shu-Yin John Leung<br>OPER, AIDS Institute, NYSDOH<br>Empire State Plaza CR342<br>Albany, New York 12237 |