



Public Health
Prevent. Promote. Protect.



Central Valley Health District

Opioid Overdose/Narcan Refill Form

Name: _____

Signature: _____ Date: ____ / ____ / ____

1.a. Was naloxone (Narcan) administered to reverse an overdose?

Yes (Skip to 2.) No (complete 1.b., below)

1.b. What happened to the naloxone that was provided to the trained overdose responder?

Lost

Expired and needs replacing

Other, Please specify: _____

[If 1.b. completed, FORM ENDS HERE]

2. How many doses of naloxone were administered? _____

3. Date of administration: ____ / ____ / ____

4. Name of the Overdose Victim (if able to release) _____

5. Physical location of administration _____

6. Gender of naloxone recipient: Male Female

7. Race of naloxone recipient: (check all that apply)

African-American/Black

Asian/Pacific Islander

Hispanic/Latino

Native American

Caucasian/White

Unknown

Other race/ethnicity, Please specify: _____



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10. Drugs used by recipient at time of overdose:

Heroin

Cocaine

Methadone

Amphetamines

Benzodiazepines

Alcohol

Prescription Opioids, Please specify: _____

Other, Please specific: _____

Unknown

11. Was the recipient conscious before administration of naloxone? Yes No Unknown

12. Was the recipient breathing before administration of naloxone? Yes No Unknown

13. Was rescue breathing performed? Yes No Unknown

14. Were Emergency Medical Services contacted? Yes No Unknown

15. Did the recipient go to hospital? Yes No Unknown

16. Did the recipient survive? Yes No Unknown

17. Please use the space below to include any information that you believe would be helpful in describing the overdose prevention incident.

Return Completed Form to Shannon Klatt (sklatt@nd.gov) at CVHD.

Form adopted 12/2018 - Edited 01/2021