



BUCKS COUNTY NALOXONE UTILIZATION QUESTIONNAIRE Police Department



GENERAL INFORMATION:					
Police Department		Date of use		Time of use (Military time)	<input type="checkbox"/> AM <input type="checkbox"/> PM
Officer name		Badge #		Incident #	
Location of incident	<input type="checkbox"/> Residence <input type="checkbox"/> Company <input type="checkbox"/> Recovery House <input type="checkbox"/> Public place (car, parking, lot, etc. – please list)				
Individual's first name and last initial			Individual's zip code		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Age	Race	
Who administered Narcan at the scene?		<input type="checkbox"/> Police <input type="checkbox"/> EMS <input type="checkbox"/> Fire <input type="checkbox"/> Other (please list below)			
How many 4 mg doses were given? (Please include the number of doses administered prior to your arrival)		<input type="checkbox"/> Police <input type="checkbox"/> EMS <input type="checkbox"/> Fire <input type="checkbox"/> Other			
Expiration date of Naloxone		I did not give Naloxone, but opened the box		<input type="checkbox"/> Yes; replacement dose requested	
How long did it take for the Naloxone to work?	<input type="checkbox"/> < 1 Min <input type="checkbox"/> 1-2 Min <input type="checkbox"/> 3-5 Min <input type="checkbox"/> > 5 Min <input type="checkbox"/> Did Not Work				
What was the result of this person's overdose? (Check <u>ONLY ONE</u>)	<input type="checkbox"/> Revived without any help <input type="checkbox"/> Revived because of my help <input type="checkbox"/> Paramedics came/person revived <input type="checkbox"/> Paramedics came/don't know what happened next <input type="checkbox"/> Don't know <input type="checkbox"/> Deceased <input type="checkbox"/> Other				
If other, please specify					
Were there any negative consequences of the overdose/treatment? (Check <u>ALL</u> that apply)	<input type="checkbox"/> Harassment <input type="checkbox"/> Anger <input type="checkbox"/> Violence <input type="checkbox"/> Vomited <input type="checkbox"/> Seizure <input type="checkbox"/> Felt sick/withdrawal <input type="checkbox"/> Arrest of overdosing person or witness <input type="checkbox"/> Other				
If other, please specify					
Please identify any stamp/wording on packaging					
Did the person seek medical care? If yes, please specify which hospital.			<input type="checkbox"/> Yes <input type="checkbox"/> No Hospital:		
Contact Information for Bucks County Drug & Alcohol Commission, Inc.					
Email Mallory Perrotti: mperrotti@buckscounty.org 55 E. Court Street, 4 th Floor, Doylestown, PA 18901 Phone: 215-444-2700 www.bcdac.org					