Quality Improvement Form
Naloxone by BLS Providers within a Respective EMS Agency

Your agency may send a copy of this form to Timothy Melton at the Emergency Health Services Federation by fax, 717-774-6163, or e-mail, tmelton@ehsf.org.

EMS Agency Name: ______
Date of Incidient: ______ PCR #: ______

BLS Provider Administering Naloxone:
Name: ______ Certification Number: ______

Patient Information:
Age (years): ______ Gender: □ male □ female
Positive History of Drug Abuse: □ yes □ no

Time of Initial Patient Contact: ______
Time of Conclusion of Patient Care: ______
Time of Onset: ______

Time of Initial Naloxone Administration: ______
Time(s) of Additional Naloxone Administration: ______

Did the patient show improvement? □ yes □ no
Did the patient's status worsen? □ yes □ no
Was ALS available? □ yes □ no
If not, why? ______
Was medical command contacted? □ yes □ no

Patient Transfer of Care:
To another EMS agency? □ yes □ no
Name of EMS Agency: ______

OR

Name of Receiving Facility: ______
Name of Receiving Facility Staff Assuming Responsibility: ______