BLS Naloxone CQI FORM

This form is to be completed by the provider who has administered Naloxone to a patient using the BLS Naloxone protocol. This form should be returned, along with a copy of the completed PCR to the Mountain Lakes office within 72 hours of administration.

Agency ________________________Transporting Agency (if different)__________________

Call Date_____/_____/_______ Hospital Destination _________________________________

Level of Care of Provider that "Pushed" the Naloxone (circle one) CFR EMT

Patient Age: _________ Gender: Male Female Blood Glucose (if obtained): ________

Initial Vital Signs: GCS: E_____V_____M_____ Heart Rate: _______ BP: ______/________

Resp. Rate & Effort: ___________________________ SPO2: _________ Pupils: __________

Final Vital Signs: GCS: E_____V_____M_____ Heart Rate: ________ BP: _______/_______

Resp. Rate & Effort: ___________________________SPO2: _________ Pupils: ___________

Airway Maintained by: Patient BVM NPA OPA

Suspected Agent/Medication Ingested:____

How many doses administered before the desired effect was achieved? __________________

Were the times for each Naloxone treatment documented? Yes / No

Were there any hazards to the crew? Yes / No If yes, what were they?

____

Were there any complications with administration? Yes / No If yes, what were they?

____

Was ALS requested? Yes / No Was ALS available and on-scene? Yes / No

Did the ALS provider administer more Naloxone IV or IM? Yes / No

Please provide any other pertinent information about this incident on the back of this page.