



**Fatal & Non-Fatal
Opioid Overdose**

Reporting (Check One):

- Non-Fatal Opioid OD
- Fatal Opioid OD
- Opioid OD, Outcome Unknown

**Report to Grant County Health District
within 48hrs of an Overdose Event**

Confidential Fax: (509) 764-2813
24hr Phone: (509) 398-2083

Submission date: _____

Patient Information

Name (last, first, MI) _____ Unk
 Home address _____
 City/State/Zip _____ Homeless
 Phone _____
 Alt contact: Parent/Guardian Spouse Other
 Contact name: _____
 Contact number: _____

Birth date _____ Unk
 Gender: M F
 MTF FTM Unk
 Race/Ethnicity (Check all that apply):
 American Indian/Alaska Native
 Asian Black/African American
 Hispanic/Latino
 Native Hawaiian/Pacific Islander
 White Other Unk

Overdose Details

Reporter name _____ Reporter phone number _____
 Agency _____ Agency record number _____
 Date of overdose event _____ Time of event (24hr clock) _____ Notification date _____
 Location of event (Address or landmark) _____ City _____ Zip _____
 Suspected substance _____ Prescribed? Yes No Unk
 Suspected route of opioid: IV Oral Snort Smoke Unk Other (Specify) _____
 Died from overdose? Yes No Death date _____ Polysubstance use? Yes No Unk
 Reason for 911 dispatch _____

Response (Check all that apply):

People involved: **Agency:**
 Law enforcement: _____
 Fire/EMS: _____
 Hospital: _____
 Coroner: _____
 Gave naloxone? Yes No Unk Dose _____ Route _____

Signs and Symptoms (Check all that apply):

Y N Unk
 Lethargy, falling asleep, altered mental status
 Hypopnea, bradypnea, apnea
 Choking or gurgling
 Constricted pupils
 Cyanosis: Skin that is pale, blue, purple
 Naloxone administered
Naloxon. response: Improved No response Unk N/A

Did civilians give naloxone? Yes No Unk
 Who administered? _____
 How much? _____
Physical evidence of recent opioid use:
Describe: _____

Transportation

If transported, where was the patient taken?

Name of facility: _____

Patient refused transport

Hospital Care

Medical record number _____

Discharged

Hospitalized at least overnight ICU

• Admit date _____

• Discharge date _____

If female, pregnant? Yes No Unk

Postpartum? Yes No Unk

Pregnancy loss? Yes No Unk

• Delivery date _____

Eloped or left without advice

Left AMA

Transferred

To: Treatment facility Detox Jail Other

Transfer facility name _____

Veteran?

Mental illness diagnosis?

Illness: _____

Died

Was patient discharged with a naloxone kit?

Yes No Unk

MOUD Initiation

Yes No Unk

Toxicology Screen Blood Urine Not performed

Y N N/A

Benzos

Barbiturates

Cocaine

THC

Methamphetamine

Methadone

Opiates

TCA

Oxycodone

MDMA

PCP

Amphetamine

Buprenorphine

Alcohol

Fentanyl

Other: Specify _____

Notes (If applicable):