

Out of the country in the last 30 days? Yes or No

If yes, where? _____



- Consumer
- Professional Staff
- Community Member
- Family Member/Personal Contact

Region 10 Naloxone Registration Form

Location: _____ Trainer: _____ Date: _____
Site/Agency

Name _____ Participant# _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Maiden Name _____

Date of Birth _____ Age _____ Race _____ Male Female

Age First Use of Opiate _____

Which Opiates Using? Heroin Methadone Other Opiates _____

In the past six months, which other drugs have you used regularly (> 1-2 times per month)?

Cocaine	YES	NO	Valium/Xanax/Ativan/Klonopin	YES	NO
Alcohol	YES	NO	Speed (including Crystal)	YES	NO
Clonidine	YES	NO	PCP	YES	NO

of times you have OD'd? _____

of times you have witnessed an OD? _____

of times 911 was called? _____ # of people went to hospital? _____ # who died? _____

Do you know or come in contact with someone who may be at risk for overdose? YES NO

Approved Prevention Educator _____ Date _____