

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 \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_ Male  Female

Age First Use of Opiate \_\_\_\_\_ Age First Needle Use \_\_\_\_\_

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

Date of last HIV test \_\_\_\_\_ Date of last HCV test \_\_\_\_\_

Would you like referral to be tested for HIV/HCV? YES NO

Approved Prevention Educator \_\_\_\_\_ Date \_\_\_\_\_