PHARMACIST NALOXONE PRESCRIPTION PROGRAM REPORTING FORM

I. PATIENT INFORMATION

1. Name: _________________________
2. Gender: ☐Male ☐Female
3. Date of Birth: __________
4. Chart Number: __________
5. Primary Care Provider: _________________________

II. PRESCRIPTION INFORMATION

1. Is this a ☐ First Prescription ☐ Refill *(check one)*

2. Amount prescribed: _______ x 2.0 mg intranasal doses

3. Reason for Naloxone Prescription (*check all that apply):*

☐Opioid dose ≥ 60mg MEDD
☐Rx for long-term opioid (any MED)
☐Rx for opioid with concurrent use of a respiratory depressant
☐Rx for opioid with known/suspected alcohol/illicit drug use
☐Current poly-opioid use
☐History of Opioid Abuse
☐Patient request for Naloxone
☐Other ______________________________*(specify)*

4. Which, if any, of the following substances does the patient currently use (has used in the past 72 hours)?

Alcohol: ☐ Yes ☐ No
Prescription Painkillers: ☐ Yes ☐ No
Marijuana: ☐ Yes ☐ No
Methadone: ☐ Yes ☐ No
Buprenorphine (Subutex®): ☐ Yes ☐ No
Buprenorphine/Naloxone (Suboxone®) ☐ Yes ☐ No
Cocaine/Crack: ☐ Yes ☐ No
Methamphetamine: ☐ Yes ☐ No
Heroin: ☐ Yes ☐ No
Benzodiazepines (e.g. Xanax®, Valium®): ☐ Yes ☐ No
Prescription Sleep Medicine: ☐ Yes ☐ No
Other _________________________________*(specify)*

5. Additional comments:

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Pharmacist Name _________________ Signature ____________________ Date ____________

Copy to be entered into Electronic Health Record, Patient Chart, and/or given to primary care provider