



**Westchester Regional Emergency Medical Advisory Committee
BLS Intra-nasal Naloxone (Narcan®) QA / QI Report Form**

IN THE EVENT OF CFR/EMT NARCAN USE COMPLETE THE FOLLOWING - Please type or print legibly

Agency Name _____

Transport Ambulance Service (if different) _____

Call Date Call Time Receiving Hospital

BLS Provider Administering Naloxone (check one) CFR EMT

PATIENT INFORMATION Gender (Check one) Female Male Age

INITIAL VITAL SIGNS

GCS: E V M Heart Rate: Respiration: Rate Quality Shallow Normal Labored

BP Blood Glucose (if available) Pupils: Dilated Normal Constricted

FINAL VITAL SIGNS

GCS: E V M Heart Rate: Respiration: Rate Quality Shallow Normal Labored

BP Blood Glucose (if available) Pupils: Dilated Normal Constricted

AIRWAY MAINTAINED BY: (Check all that apply) Patient BVM OPA NPA Suction
SUSPECTED OPIOID USE BY PATIENT: YES NO **Source of information** Patient Family/Bystander Police Other _____

Number of doses necessary to achieve desired effect

Time(s) of each dose of Naloxone administration documented on PCR YES NO

Any hazards to the crew? If YES, please describe on back of the form. YES NO

Were there any complications post-Naloxone administration? YES NO
 If YES, please indicate: Respiratory Distress Vomiting Combativeness Other _____

Was ALS requested? YES NO

Was ALS available and on-scene? YES NO

Did ALS administer additional Naloxone? YES NO

**Send this form and a copy of the PCR to the Westchester Regional EMS Office within 24 hours of administration by
FAX (914-813-4161) or EMAIL admin@wremsco.org.**

Please provide any other pertinent information and/or comments regarding this event on the back of this page.
 Check here if the back of this sheet was used for additional comments.