This form **MUST** be completed with every MFR/BLS Study Naloxone Kit use. It **MUST** be attached to the run report *and sent* to HEMS for tracking purposes.

Phone: 734 727-7280  Fax: 734 727-7281  Email: mail@hems.org

AGENCY/UNIT: _______________________________________________ / ______________

DATE: _______________________               INCIDENT NUMBER: _____________________

EMS CREW (NAMES) ______________________________________________ ________

Receiving Hospital:  __________________________________________ ____________

Patient Chief Complaint:  _____________________________________ _________________

Were you confident in your ability to draw up and administer the required initial dose of Naloxone (Narcan)?

YES ☐    NO ☐

Please explain: _______________________________________________ _____________
____________________________________________________________________________

Did the Naloxone (Narcan) improve the patient’s condition?

(No te: Treatment goal is adequate patient breathing effort; the patient need not be woken up completely)

YES ☐    NO ☐

Please explain: _______________________________________________ _____________
____________________________________________________________________________

Did the patient require a second dose?

YES ☐    NO ☐

Please explain: _______________________________________________ _____________
____________________________________________________________________________