

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: _____

Gender Identity: Male Female Prefer not to say Prefer to self-describe _____

Do you identify as transgender? Yes No Prefer not to say

Are you using any opiates? Please circle all the apply.

Heroin Methadone Other Opiates

If you have ever used opiates, what age did you first use? _____ N/A

In the past six months, have you used any of the following drugs regularly (more than 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: _____