



## Prevention Point Philadelphia - Participant Training Form

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name (write as clearly as possible):

☐ Check if you are a staff member

Unique ID#: \_\_\_\_\_ SEP#: \_\_\_\_\_  
1<sup>st</sup> letter of last name &  
last 4 digits of SS#

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_ Race: \_\_\_\_\_

Are you carrying Naloxone today? ☐ Yes ☐ No

Do you currently have insurance? ☐ Yes ☐ No

Have you ever overdosed before? ☐ Yes ☐ No

**If YES:**

➔ How many times? \_\_\_\_\_

➔ When was your most recent overdose?

\_\_\_\_\_

**What was the outcome of the OD? (Check all that apply)**

- ☐ EMS
- ☐ Police arrived at the scene
- ☐ Emergency Room and/or Hospitalization
- ☐ Unknown

Have you ever witnessed a drug overdose? ☐ Yes ☐ No

**If YES, how many?**

- ☐ < 5
- ☐ 5-10
- ☐ 11-15
- ☐ 16-20
- ☐ 21+ (how many?) \_\_\_\_\_

**When was the last time you witnessed an overdose?**

- ☐ < 1 week
- ☐ 1 week to 1 month
- ☐ 1-3 months
- ☐ > 3 months

Staff/Volunteer \_\_\_\_\_

Date \_\_\_\_\_

**In the last 90 days, have you used:**

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Heroin    | <input type="checkbox"/> Vicodin/Hydrocodone |
| <input type="checkbox"/> OxyContin | <input type="checkbox"/> Codeine             |
| <input type="checkbox"/> Methadone | <input type="checkbox"/> Other Opiates       |
| <input type="checkbox"/> Cocaine   | <input type="checkbox"/> K2                  |
| <input type="checkbox"/> Valium    | <input type="checkbox"/> Xanax               |
| <input type="checkbox"/> Ativan    | <input type="checkbox"/> FENTANYL            |
| <input type="checkbox"/> Other:    |  |

**In the last 90 days, have you gone 3 or more days without opiates?** ☐ Yes ☐ No

**If YES, why?**

- ☐ Inpatient/Outpatient Drug Treatment
- ☐ Hospital
- ☐ Jail
- ☐ No money
- ☐ Decided to take a break
- ☐ Other: \_\_\_\_\_

**Have you ever been diagnosed with any of the following health conditions? (Check all that apply.)**

- |  |   |
|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arrhythmia     |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Asthma         |
| <input type="checkbox"/> Endocarditis        | <input type="checkbox"/> COPD           |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Liver Disease  |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Immune Disorder     | <input type="checkbox"/> Bipolar        |
| <input type="checkbox"/> Schizophrenia       | <input type="checkbox"/> Diabetes       |
| <input type="checkbox"/> Other:              | _____                                   |

**Who are you getting Naloxone for today?**

- ☐ Yourself
- ☐ Friend
- ☐ Family member
- ☐ Client
- ☐ Just to carry

**Which category best describes you?**

- ☐ Person who uses drugs
- ☐ Person in recovery
- ☐ Parent of a user
- ☐ Friend
- ☐ Provider
- ☐ Other: \_\_\_\_\_

# Prevention Point Philadelphia Naloxone Checklist & Order to Dispense

Participant Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Unique ID: \_\_\_\_\_  
1<sup>st</sup> letter of last name & last 4 digits of SS#

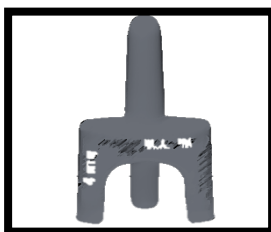


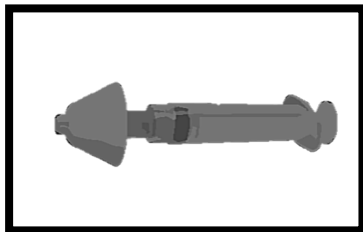
**Participant Initials the following:**

	<p><b><u>Overdose Risk Factors</u></b> Mixing drugs (e.g. opiates and benzos); loss of tolerance after a period of abstinence (e.g. following release from prison/jail, after hospitalization, inpatient detox or rehab); developing high tolerance and using more than one can handle (in order to feel the high again); unknown purity or quality (e.g. heroin laced with fentanyl); using alone or when staying away from family; certain medical conditions, including immune disorder, HIV, Hep C, breathing issues (e.g. apnea, COPD), heart disease. <b>Educate those you use with!</b> Purity testing ("tasting," snorting, gradual injecting), don't use more than you can handle, don't use alone!</p>
	<p><b><u>Overdose Symptoms Recognition</u></b> Extreme sleepiness; Slower breathing; Non-responsive to loud noise, touch, or pain; Turning blue or purple <b>Call 911!</b></p>
	<p><b><u>Rescuer Safety</u></b> Remove hazardous materials, used syringes, etc., If you have gloves wear them; Use a barrier for rescue breathing- T-shirt, paper cup, saran wrap, dental dam. Anyone who is too stressed out, too high, or does not want to be around if police come should leave.</p>
	<p><b><u>Rescue Breathing</u></b> Clear airway; put in Recovery Position if breathing On back, forehead back, tip chin to open airway Remember to clear mouth and pinch off nose, seal your mouth over theirs Two quick breaths to begin, then 1 breath every four seconds</p>
	<p><b><u>Naloxone - store away from light and at room temperature</u></b> Keep Naloxone and IM (1 - 1 1/2" long) needles with your works, inject 1cc. or 1 ml. into shoulder; butt cheek; thigh. OR put two vials in intranasal kit together and twist on atomizer, then spray up to 2 mL at a time in each nostril. OR spray on nasal Narcan pump into one nostril and wait. <b>Keep breathing for them</b> until Naloxone starts to work and they start breathing on their own. If not working in 5-10 minutes, give a second dose. <b>If 2<sup>nd</sup> dose doesn't work, something else may be wrong.</b> <b>GET HELP, call 911 immediately!</b></p>
	<p><b><u>911 Calls &amp; Working with EMTs - We strongly recommend calling 911!</u></b> Try to speak calmly and tell the operator "My friend is unconscious and not breathing" and where you are; remove all drugs and paraphernalia from sight; tell EMTs what they've taken and what measures you have taken to bring them back—remember that they are there to help! <b>GET MEDICAL ATTENTION AFTER THEY ARE REVIVED, EVEN IF THEY SEEM FINE THEY MAY HAVE OTHER PROBLEMS YOU CAN'T SEE!! LET PERSON KNOW IF THEY USE AGAIN, THEY OVERDOSE AGAIN.</b></p>

**Participant Consent:** By signing below, I give my permission for Prevention Point Philadelphia to provide feedback to verify that I have completed Opiate Overdose Prevention training. I also acknowledge that my information is private and confidential and will only be reported on in the aggregate form and my name will not be linked to my medical information for reporting purposes. My consent is valid through the duration of the OPIATE Project.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Staff Name: \_\_\_\_\_

				<p># Units shown _____</p> <p>Lot # _____</p> <p>Exp. Date _____</p>
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What program did the person you trained come from?

☐ SHP   ☐ SEP-on-site   ☐ SEP-mobile   ☐ CM   ☐ WN   ☐ WCC   ☐ Drop In   ☐ Testing   ☐ External (provider/parent/community)

What program's medication was used for training?

☐ SHP   ☐ SEP-on-site   ☐ SEP-mobile   ☐ CM   ☐ WN   ☐ WCC   ☐ Drop In   ☐ Testing   ☐ External (provider/parent/community)