

NALOXONE INTAKE FORM *(standard)*

FOR OFFICE USE ONLY

Form identification number: _____ Date of Kit Distribution: ___/___/___ Number of kits provided: _____ Kit is for: <input type="radio"/> Individual <input type="radio"/> Service entity How is this naloxone funded? <input type="radio"/> ODH (General Allocation and/or IN Grant) <input type="radio"/> Other _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: center;">Distribution Setting:</th> </tr> <tr> <td style="width: 50%; vertical-align: top;"> <input type="radio"/> Community Access Point <input type="radio"/> Corrections/Court System <input type="radio"/> ED/Urgent Care <input type="radio"/> FQHC/non-LHD Clinic <input type="radio"/> Hospital System <input type="radio"/> Lay Distribution Network <input type="radio"/> Leave-Behind (EMS/LEO) <input type="radio"/> Local Health Department (LHD) <input type="radio"/> Mobile Unit </td> <td style="width: 50%; vertical-align: top;"> <input type="radio"/> Online Mail-order <input type="radio"/> Pharmacy <input type="radio"/> QRT <input type="radio"/> School/University <input type="radio"/> Street Outreach <input type="radio"/> Syringe Service Program <input type="radio"/> Treatment/Recovery <input type="radio"/> Other _____ </td> </tr> <tr> <td colspan="2" style="text-align: center;"> County of Distribution Setting: _____ <input type="radio"/> N/A (online) </td> </tr> </table>	Distribution Setting:		<input type="radio"/> Community Access Point <input type="radio"/> Corrections/Court System <input type="radio"/> ED/Urgent Care <input type="radio"/> FQHC/non-LHD Clinic <input type="radio"/> Hospital System <input type="radio"/> Lay Distribution Network <input type="radio"/> Leave-Behind (EMS/LEO) <input type="radio"/> Local Health Department (LHD) <input type="radio"/> Mobile Unit	<input type="radio"/> Online Mail-order <input type="radio"/> Pharmacy <input type="radio"/> QRT <input type="radio"/> School/University <input type="radio"/> Street Outreach <input type="radio"/> Syringe Service Program <input type="radio"/> Treatment/Recovery <input type="radio"/> Other _____	County of Distribution Setting: _____ <input type="radio"/> N/A (online)	
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Age 14 or under 15-24 25-34 35-44 45-54 55-64 65+

What sex were you assigned at birth, on your original birth certificate? Male Female Prefer not to say

Do you consider yourself to be transgender or non-binary? Yes No Prefer not to say

If yes, do you consider yourself to be:

- Male-to-female
- Female-to-male
- Non-binary
- Prefer not to say

What race(s) and ethnicity do you consider yourself? Please choose one.

- White Black/African American Hispanic/Latino Asian Native Hawaiian/Pacific Islander
- American Indian or Alaska Native Other Prefer not to say
- Multi-racial/multi-ethnic (check all that apply below)

- | |
|---|
| <div style="border-left: 1px solid black; border-bottom: 1px solid black; width: 100px; height: 15px; margin-left: 10px;"></div> <div style="margin-left: 10px;"> <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian
 <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other </div> |
|---|

In which Ohio county do you live? _____ Prefer not to say I do not live in Ohio

Is this the first naloxone (Narcan) kit you have received? Yes No

If no, what happened to your previous kit?

- My kit was used on another person who was overdosing → Did the person survive? Yes No
- My kit was used on me
- The medication in my kit expired
- Other

Intended use for naloxone (Narcan): <input type="checkbox"/> If I overdose <input type="checkbox"/> If a friend or family member overdoses <input type="checkbox"/> If I see someone overdose	How many times have you witnessed someone overdosing? <input type="radio"/> 0 (never) <input type="radio"/> 1 to 10 <input type="radio"/> More than 10 <input type="radio"/> Prefer not to say
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Do you have health insurance?

- No Yes, I have Medicaid Yes, I have other insurance Unknown Prefer not to say

Yes	No	Have you...
<input type="radio"/>	<input type="radio"/>	...been released from a jail or correctional facility within the past 30 days?
<input type="radio"/>	<input type="radio"/>	...been released from an inpatient treatment facility within the past 30 days?
<input type="radio"/>	<input type="radio"/>	...ever been in a formal treatment program (other than AA, NA, or other peer support groups)?
<input type="radio"/>	<input type="radio"/>	...ever used intravenous (IV) drugs?
<input type="radio"/>	<input type="radio"/>	...ever used drugs <u>other</u> than opioids, such as cocaine and methamphetamine?
<input type="radio"/>	<input type="radio"/>	...ever overdosed?