WREMAC BLS Naloxone
Sample QA Form

This form is can be used to meet the internal QA requirements. Agencies must review all BLS Naloxone administrations for at least the first 6 months.. Please retain completed form as part your agencies QA records.

Agency: _____

Transporting Ambulance (if different): _____

Call Date: _____ PCR or PRID#: _____

Hospital Destination: _____

Level of care of provider administering Naloxone treatment:

☐ CFR/EMR ☐EMT ☐ AEMT-I ☐ AEMT-CC or P

Patient information:

Age: _____ Gender: ☐Male ☐Female Blood Glucose (if obtained): _____

Initial Vital Signs: GCS: E___V___M___ Heart Rate: _____ Blood Pressure: _____/_____

Resp. Rate & Effort: _____ SPO2: _____ Pupils:_____

Final Vital Signs: GCS: E___V___M___ Heart Rate: _____ Blood Pressure: _____/_____

Resp. Rate & Effort: _____ SPO2: _____ Pupils:_____

Airway Maintained by Patient BVM NPA OPA

Suspected Agent/Medication Ingested: _____

1. Was Naloxone administered to this patient? Yes ☐/ No ☐
2. How many doses were administered before the desired effect was achieved? _____
3. Were the times for each Naloxone treatment documented? Yes ☐/ No ☐
4. Were there any hazards to the crew? Yes ☐/ No ☐ If yes, what were they?

   ☐Combative ☐ Violent ☐ Other:_____

5. Were there any complications with administration? Yes ☐/ No ☐ If yes, what were they?

   ☐Respiratory distress ☐Vomiting ☐Other: _____

6. Was ALS response requested? Yes ☐/ No ☐
7. Was ALS response available and on-scene? Yes ☐/ No ☐
8. Did ALS administer more Naloxone IV or IM? Yes ☐/ No ☐

Please provide any other pertinent information / comments about this encounter on the back of this page.