

# Emergency Department Non-Fatal Drug Overdose Case Reporting Form



Please submit to the Ohio Department of Health via secure fax at 614-564-2455. Cases should be reported within two business days following diagnosis.

## Patient Demographics:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Address (Include Street, City, State/Country, ZIP Code, and County) *(Only Report Ohio Residents):* \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Social Security Number (Last Four Digits Only): \_\_\_\_\_ Sex at Birth: ☐ Male ☐ Female ☐ Unknown

Current Gender Identity: ☐ Male ☐ Female ☐ Transgender Male to Female (MTF)

☐ Transgender Female to Male (FTM) ☐ Unknown ☐ Other Gender Identity: \_\_\_\_\_

Pregnant: ☐ Yes ☐ No ☐ Unknown

If Pregnant, As-Of Date: \_\_\_\_\_ Due Date: \_\_\_\_\_ Number of Weeks: \_\_\_\_\_

Race (Select All That Apply): ☐ White ☐ Black ☐ American Indian or Alaskan Native ☐ Asian

☐ Hawaiian Native or Pacific Islander ☐ Other \_\_\_\_\_ ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Deceased: ☐ Yes ☐ No ☐ Unknown If Deceased, Date of Death: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_ Employed: ☐ Yes ☐ No ☐ Unknown

## Clinical:

ED Admission Source: \_\_\_\_\_

ED Admission Date: \_\_\_\_\_ ED Admission Time: \_\_\_\_\_  
(hh:mm/24-hour clock)

ED Discharge Date: \_\_\_\_\_ ED Discharge Time: \_\_\_\_\_  
(hh:mm/24-hour clock)

ED Discharge Disposition: \_\_\_\_\_

Inpatient Admission Date: \_\_\_\_\_ Inpatient Admission Time: \_\_\_\_\_  
(hh:mm/24-hour clock)

Inpatient Discharge Date: \_\_\_\_\_ Inpatient Discharge Time: \_\_\_\_\_  
(hh:mm/24-hour clock)

Inpatient Discharge Disposition: \_\_\_\_\_

**Diagnosis Codes** *(Select All That Apply):*

Opium:  
Heroin:  
Other Opioids:  
Methadone:  
Fentanyl or Fentanyl Analogs:  
Tramadol:  
Other Synthetic Narcotics:  
Cocaine:  
Unspecified Narcotics:  
Other Narcotics:  
Benzodiazepines:  
Unspecified Psychostimulants:  
Amphetamines:  
Methylphenidate:  
Other Psychostimulants:  
Unspecified Drugs:  
Other Drugs:

**Accidental:**

☐ T40.0X1A  
☐ T40.1X1A  
☐ T40.2X1A  
☐ T40.3X1A  
☐ T40.411A  
☐ T40.421A  
☐ T40.491A  
☐ T40.5X1A  
☐ T40.601A  
☐ T40.691A  
☐ T42.4X1A  
☐ T43.601A  
☐ T43.621A  
☐ T43.631A  
☐ T43.691A  
☐ T50.901A  
☐ T50.991A

**Intentional self-harm:**

☐ T40.0X2A  
☐ T40.1X2A  
☐ T40.2X2A  
☐ T40.3X2A  
☐ T40.412A  
☐ T40.422A  
☐ T40.492A  
☐ T40.5X2A  
☐ T40.602A  
☐ T40.692A  
☐ T42.4X2A  
☐ T43.602A  
☐ T43.622A  
☐ T43.632A  
☐ T43.692A  
☐ T50.902A  
☐ T50.992A

**Assault:**

☐ T40.0X3A  
☐ T40.1X3A  
☐ T40.2X3A  
☐ T40.3X3A  
☐ T40.413A  
☐ T40.423A  
☐ T40.493A  
☐ T40.5X3A  
☐ T40.603A  
☐ T40.693A  
☐ T42.4X3A  
☐ T43.603A  
☐ T43.623A  
☐ T43.633A  
☐ T43.693A  
☐ T50.903A  
☐ T50.993A

**Undetermined:**

☐ T40.0X4A  
☐ T40.1X4A  
☐ T40.2X4A  
☐ T40.3X4A  
☐ T40.414A  
☐ T40.424A  
☐ T40.494A  
☐ T40.5X4A  
☐ T40.604A  
☐ T40.694A  
☐ T42.4X4A  
☐ T43.604A  
☐ T43.624A  
☐ T43.634A  
☐ T43.694A  
☐ T50.904A  
☐ T50.994A

## Reporting Facility:

**Facility Name:** \_\_\_\_\_ **Facility Type:** \_\_\_\_\_ **Facility NPI:** \_\_\_\_\_

**Facility Address** *(Include Street, City, State, ZIP Code, and County):*

\_\_\_\_\_

**Person Completing Form:** \_\_\_\_\_ **Contact Phone Number:** \_\_\_\_\_

## Toxicology:

**Toxicology Performed:** ☐ Yes ☐ No ☐ Unknown **Toxicology Collect Date:** \_\_\_\_\_

**Alcohol:** ☐ Present ☐ Not Present ☐ Not Tested **Alcohol Testing Performed Date**  
*(If Alcohol is Present):* \_\_\_\_\_

**Blood Alcohol Concentration Level** *(If Alcohol is Present):* \_\_\_\_\_

**Amphetamines:**

**Benzodiazepines:**

**Muscle Relaxants:**

**Anticonvulsants:**

**Cocaine:**

**Opioids:**

**Antidepressants:**

**Fentanyl:**

**Xylazine:**

**Antipsychotics:**

**Gabapentin:**

**Other Drug Present:**

**Barbiturates:**

**Marijuana:**

## Epidemiology:

**Type of Unintentional Drug Overdose:** \_\_\_\_\_ **Other** *(If Selected):* \_\_\_\_\_

**Route of Drug Administration:** \_\_\_\_\_ **Other** *(If Selected):* \_\_\_\_\_

**Naloxone Administered by** *(Select All That Apply):* ☐ Administered but unknown by whom ☐ Bystander ☐ EMS/Fire  
☐ Hospital ☐ Law Enforcement ☐ Not Administered ☐ Unknown if Administered ☐ Other: \_\_\_\_\_

**History of Any Opioid** *(e.g., Prescription, Heroin, Fentanyl)* **Misuse or Harmful Use:** ☐ Yes ☐ No ☐ Unknown

**History of Previous Drug Overdose(s):** ☐ Yes ☐ No ☐ Unknown

**Was Patient Referred to Treatment for a Substance Use Disorder:** ☐ Yes ☐ No ☐ Unknown

**OD Event Location** *(Include Street, City, State, ZIP Code, and County):*

\_\_\_\_\_