Naloxone Registration

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last insurance verification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Overdose education \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Narcan administration education \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Pharmacy Consent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By my signature below, I certify that I have accepted the prescription delivered by Philadelphia Pharmacy to Addiction Medicine and Health Advocates on my behalf as requested.

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| --- | --- | --- | --- | --- | --- |
| **RX date** | **Received by** | **Received Date** | **Patient Signature** | **Date** | **Staff initials** |
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