[FACILITY NAME]

Medical Director's Office | Long-Term Care Services

SUBSTANCE USE SAFETY & BEHAVIORAL AGREEMENT

Confidential — Part of the Medical Record

Resident Name:	**Date of Birth:**
Room / Unit:	**Medical Record #:**
Attending / Medical Director:	**Date of This Agreement:**

1. PURPOSE OF THIS AGREEMENT

This agreement documents a discussion between the resident named above ("you"/"the resident"), the medical director/attending physician, and the interdisciplinary care team regarding ongoing substance use (alcohol and/or drug use) that has been identified as a safety concern. It is intended to support your autonomy and dignity while making sure you, the care team, and your family/representative share a clear, honest understanding of the risks involved and the plan to keep you as safe as possible.

This is not a punitive document. Signing does not waive your rights as a resident, and declining to sign does not remove your right to services. It is a record that the risks below were explained to you, that treatment and support options were offered, and of the plan we have agreed to going forward.

2. SUBSTANCE(S) AND PATTERN OF USE IDENTIFIED

Substance(s) involved:	**Frequency / typical amount:**
Usual setting (in-facility / off-grounds):	**Known triggers or context:**

3. RISKS DISCUSSED WITH THE RESIDENT

The following risks were reviewed in detail. Unchecked items are not currently applicable; all checked items were specifically discussed:

- ☐ Interactions between substance(s) and current prescribed medications (sedation, respiratory depression, bleeding risk, arrhythmia, altered drug metabolism)
- ☐ Falls and fall-related injury (fracture, head injury, subdural hematoma), including while intoxicated on facility grounds or off-grounds
- ☐ Pedestrian/traffic injury when leaving the facility to obtain or use substances (crossing streets while impaired)
- ☐ Alcohol toxicity, overdose, and withdrawal complications including seizures and delirium tremens
- ☐ Opioid or polysubstance overdose and respiratory arrest
- ☐ Cirrhosis, hepatic failure, GI bleeding, and pancreatitis from chronic alcohol use

☐ Accelerated cognitive decline, alcohol-related dementia, and impaired decision-making capacity over time

☐ Malnutrition, unintentional weight loss, and vitamin deficiency (e.g., thiamine/Wernicke-Korsakoff risk)

☐ Aspiration risk when intoxicated

☐ Infection risk (injection-related, or from impaired wound healing/immune status)

☐ Elopement or unsafe wandering while impaired

☐ Impaired judgment increasing vulnerability to financial or physical exploitation by others

☐ Risk to roommates/other residents (secondhand exposure, disruptive behavior, shared space safety)

☐ Other (specify): _____

Resident's understanding acknowledged by initials: _____

Family / Healthcare Representative initials (if involved): _____

4. TREATMENT AND SUPPORT OFFERED

The following were offered to the resident as part of this discussion (check all that apply):

☐ Individual substance use counseling / behavioral health consultation

☐ Medication for alcohol use disorder (e.g., naltrexone, acamprosate, disulfiram) discussed and offered

☐ Medication for opioid use disorder (e.g., buprenorphine) discussed and offered

☐ Referral to outpatient substance use treatment program

☐ Referral to inpatient/residential substance use treatment or medical detoxification

☐ Replacement/diversion activities (structured social, recreational, or vocational activities to reduce use triggers)

☐ Supervised or facility-monitored use arrangement (if applicable and feasible)

☐ Nutrition consult / thiamine and vitamin repletion

☐ Social work involvement for family and psychosocial support

Resident's response to offers (accepted / declined / undecided, with brief detail):

5. SAFETY AND MONITORING PLAN GOING FORWARD

Communication plan

- Care team will attempt a check-in call/contact with the resident when off facility grounds, at agreed intervals, to confirm safety and wellbeing.
- Resident may contact nursing staff, social work, or the on-call provider at any time using: _____ to request help, report distress, or ask for support before or during use.
- A designated staff contact for this plan is: _____ (name/role).

Monitoring upon return to the facility

- Vital signs and a focused safety assessment (including fall risk and level of intoxication/withdrawal signs) will be completed upon the resident's return.
- Standardized withdrawal monitoring (e.g., CIWA-Ar for alcohol, COWS for opioids) will be initiated per facility protocol when clinically indicated.
- Threshold for escalation to emergency services will be defined in the resident's standing orders.

Social environment

- The care team will remain alert for visitors or peers who may be supplying substances or encouraging use, and will discuss this directly with the resident, offering options to set boundaries with specific individuals if the resident wishes.

Review

- This agreement will be reviewed at the next care conference, or sooner if the resident's condition, safety, or preferences change.

6. IF SUBSTANCE USE AND ASSOCIATED RISK CONTINUE

The care team's priority remains your safety and continuity of care. If risk remains high despite the supports above, the team may need to discuss further steps, which can include an updated risk assessment, additional family/representative involvement, a capacity evaluation, or — if criteria are met and less restrictive options have been exhausted — a referral for evaluation of involuntary commitment for substance use treatment under Colorado law (C.R.S. Title 27, Article 81), consistent with Colorado Behavioral Health Administration procedures.

7. ACKNOWLEDGMENT

By signing below, I acknowledge that the risks and options above were explained to me in a way I understood, that I had the opportunity to ask questions, and that I am choosing to accept the associated risks of continued substance use to the extent I continue to engage in it. I understand I can revisit this conversation and these options at any time.

Resident

Signature:	**Date:**

Resident (or Healthcare Representative if resident lacks capacity for this decision — indicate authority below)

Physician / Medical Director

Signature:	**Date:**

Print name and title

Witness

Signature:	**Date:**

Print name and role (e.g., charge nurse, social worker)

Distribution: Original to medical record. Copy offered to resident/representative. Copy to social work file.