Overdose Risk Assessment and Safety Planning Worksheet

Different drugs have different effects, and some drugs are more likely to cause an overdose than others. Overdosing on opioids may cause slower heart rate and breathing. Overdosing on stimulants (overamping) may cause a variety of symptoms that last for some time, including faster heart rate, agitation, chest pain and anxiety. This worksheet can help you identify changes in drug use practices that could decrease your overdose risk.

This worksheet is voluntary. You can skip questions you do not want to answer at any time. Please do not provide any personally identifying information, such as your name, date of birth or address. This worksheet is confidential; any information you provide will not result in punitive actions regarding reported drug use. Your information should be stored securely (either by you when you take this worksheet with you after your session or by the case manager if they keep the worksheet for you). Do not provide information about drug use that may affect your residency or services you receive.

Drug Use Practices

Which drugs (prescription or nonprescription) do you usually use? (Select all that apply.)
□ Heroin or fentanyl □ Crack or cocaine □ Crystal meth □ Pills (opioids) □ Pills (benzodiazepines)
□ Alcohol □ Other: _____

How do you use these drugs? (Select all that apply.)
□ Sniff or snort □ Smoke □ Inject □ Swallow □ Other: _____

How much of these drugs do you usually use at the same time (for example, one bag, 2 grams or it varies)?

_____

The following sections can help you assess your risk for overdose and think about ways you can reduce your risk.

Drug Testing Strips

Do you use fentanyl or xylazine test strips to test your drugs? □ Yes □ No

If **yes**:

- **How often do you use test strips to test your drugs?** _____
- **Which drugs do you test?** _____
- **What do you do if your drugs test positive?**

  _____
- **What do you do if your drugs test negative?**

  _____

Combining Drugs

Do you usually use more than one drug at the same time? □ Yes □ No

If **no**, skip to Tolerance and Medication for Opioid Use Disorder.

If **yes**:

- **Which types of drugs? (Select all that apply.)**
  □ Stimulants □ Depressants □ Antipsychotics □ Hallucinogens
- **In what order do you take these drugs?**
  _____
- **Could you avoid using more than one drug at the same time?** □ Yes □ No

If you cannot avoid using more than one drug at the same time, could you:

- **Use less of each drug?** □ Yes □ No
- **Wait to see how I feel before using another drug?** □ Yes □ No

Tolerance and Medication for Opioid Use Disorder

Have you ever stopped using drugs, even for one or two days? □ Yes □ No

If **yes**, when you use drugs after a break, could you:

- **Use less than your usual amount in case your tolerance decreased?** □ Yes □ No
- **Use more slowly (for example, sniff less, inject slower or add more water to your shot)?** □ Yes □ No

Are you currently taking medication for opioid use disorder (MOUD), such as methadone or buprenorphine (bupe)? □ Yes □ No

If **yes**, do you have enough of your prescription to last until your next appointment?
□ Yes □ No

If **no**, are you interested in learning more about MOUD to help manage your opioid use? □ Yes □ No

Naloxone

Where can you get a naloxone kit if you do not have one or if you used or lost yours? If you are not sure, discuss your options with the staff assisting you.

_____

Where can you keep naloxone kits in case you need one?

_____

What might prevent you from carrying a naloxone kit?

_____

Do you keep your naloxone kit in plain sight while you use drugs? □ Yes □ No

Are there people around you who have their own naloxone kit? □ Yes □ No □ Unsure

Are there people around you who know how to use naloxone? □ Yes □ No □ Unsure

Are there people around you who know where you keep your naloxone? □ Yes □ No □ Unsure

Is naloxone easily accessible in the setting where you usually use drugs? □ Yes □ No

Setting

Where do you usually use drugs?

_____

Does the setting where you usually use drugs have a door? □ Yes □ No

If **yes**, does the door lock? □ Yes □ No

Will someone be able to see you in this setting? □ Yes □ No

Will someone be able to check on or get to you if you overdose in this setting? □ Yes □ No

Do you have to rush when you use in the setting? □ Yes □ No

Is there a sterile area where you can prepare your drugs? □ Yes □ No

If **yes**, is the area well-lit? □ Yes □ No

What can you do to make the setting where you usually use drugs safer?

_____

People Who Can Help

Do you use alone or with other people?

□ Alone □ With one other person □ In a group □ Sometimes alone, sometimes with others

Do you have a cell phone? □ Yes □ No □ Sometimes

If **yes** or **sometimes**, could you set a timer or alarm on your phone for three to five minutes so someone nearby could check on you if you are unable to turn off the timer or alarm?
□ Yes □ No

If or when you use alone, is there someone nearby who can check on you? □ Yes □ No

If **yes**, could I ask the person to check on me if they do not hear from you in three to five minutes? □ Yes □ No

If **no**, could you call or text someone who will send help if they do not hear from you in three to five minutes? □ Yes □ No

If **no**, could you call the Never Use Alone hotline at 877-696-1966? □ Yes □ No

If or when you use with other people:

- **Could you use one person at a time (staggered use) in case one of you overdoses?**
  □ Yes □ No

- **Could you keep naloxone on hand in case one of you overdoses?** □ Yes □ No
- **Have you talked about how to keep each other safe if one of you overdoses?**
  □ Yes □ No
  If **no**, how could you start the conversation? □ Share my safety plan
  □ Ask them about their safety plans □ Tell them where I keep my naloxone
  □ Other: _____

Overall Health

Do you have any medical conditions that affect your breathing?
□ Asthma □ Chronic obstructive pulmonary disease (COPD) □ Bronchitis □ Respiratory virus
□ Allergies □ Other: _____

Are you taking medications for these medical conditions as prescribed? □ Yes □ No
If **yes**, are the medications controlling your symptoms? □ Yes □ No
If **yes**, do you have enough medications until your next appointment?
□ Yes □ No
If **no**, can you call your health care provider to make a follow-up appointment?
□ Yes □ No
If **no**, can you get a refill or make a follow-up appointment with your health care provider?
□ Yes □ No

Do you smoke any of these substances?
□ Tobacco □ Cannabis □ K2 □ Crack □ Other: _____

Are you interested in learning about options to quit or reduce your smoking of these substances?
□ Yes □ No

Are you interested in using nicotine patches or gum to reduce your tobacco use?
□ Yes □ No

My Overdose Safety Plan

Reasons I do not want to overdose:

_____

Risks I am likely to take:

_____

Risks I am <u>not</u> likely to take:

_____

Strategies to reduce my risk of overdose:

_____

How I can keep myself safe if I use alone:

_____

How I can keep myself safe if I use with other people:

_____

Things that make it hard for me to use more safely:

_____

Resources I can access to improve my health and reduce my risk of overdose and other harms (for example, syringe service programs, overdose prevention centers and drug-checking sites):

_____

Steps I can take to improve my health and reduce my risks:

_____