CRISIS PLAN

Client Name: _____ **DOB:** _____

Client Phone #: _____ **Behavioral Health Agency:** _____

Client Information

Primary Language: _____ Interpreter Needed: ☐ Yes ☐ No

Type of residence (check one): ☐ Facility ☐ Independent ☐ Foster ☐ Care Group Care (Youth) ☐ No residence

Residence Address: _____
STREET CITY STATE ZIP

Emergency Contact/Next of Kin/Natural Support: _____

Phone: _____ Active ROI: _____

Advanced directive: ☐ Yes ☐ No *If yes, where is it?* _____

LR: _____ Expiration Date: _____ Current Access to Firearms: ☐ Yes ☐ No

History of violence: ☐ Yes ☐ No *List methods, weapons and any recent dates below.*

History of suicide/self-harm: ☐ Yes ☐ No *List methods and any recent dates below.*

Substance use: ☐ Yes ☐ No *List all substances used including the type and frequency below.*

Baseline Behavior/Mental Status: klhlio

Health History

Psychiatric Diagnoses: _____

Medical Diagnoses, if known: _____

Allergies: _____

Prescribed medications *(include date(s) prescribed)*: _____

Useful Interventions/Recommendations: _____