Crisis Contact Data

Consumer Name:_____ ID:_____

Date of Call: M_____ D _____ Y _____ Time of Crisis Call: hh/mm _____

Date of Response: M_____ D _____ Y _____ Time Linked to MR/DD Staff: hh/mm _____

Link to MR/DD Staff Not Required ☐ Reason: _____

Phone Triage Code: _____ On-Call Response Triage Code: _____

DOB: mm/dd/yy Gender: ☐ Male ☐ Female

Region: Co. of Residence:

Telephone Time: Start_____ Out _____ LOS (minutes)_____

Travel Time: Start_____ Out _____ LOS (minutes)_____

Face-to-Face Time: Start_____ Out _____ LOS (minutes)_____

Total Length of Service (LOS minute total)

Indication of Intellectual/Cognitive Deficit: Yes ☐ No ☐

Indication of Current Substance Abuse: Yes ☐ No ☐

If yes, identify substance(s) if known:_____

New Crisis Services Consumer: Yes ☐ No ☐ Existing Crisis Consumer: Yes ☐ No ☐
Date of Last Known Prior Contact By Crisis Services: mm/dd/yy _____
Existing Crisis Plan: Yes ☐ No ☐ Access to Existing Crisis Plan: Yes ☐ No ☐
Psychiatric Advanced Directive: Yes ☐ No ☐
Medical Advance Directive: Yes ☐ No ☐

Contact Numbers: Guardian: Yes ☐ No ☐ Power of Attorney: Yes ☐ No ☐

Guardian/POA Name _____ Number _____

Caller/Relationship _____ Number _____

Person/Relationship Number

Diagnostic Information (All 5 Axes Required): Specify DSM ☐ ICD ☐

	Code	Diagnosis/Notations
Axis 1:	_____	_____
Axis 2:	_____	_____
Axis 3:	_____	_____
Axis 4:	_____	_____
Axis 5:	_____	_____

Signature/Credentials of Person Completing Form_____

Crisis Contact Data

Criminal Justice Involvement (probation, parole, pending charges): Yes ☐ No ☐
Psychiatric Inpatient Service History: Yes ☐ No ☐

Race:
☐ Black/African Amer. ☐ White/Anglo/Caucasian ☐ Amer. Indian/Native American
☐ Hispanic ☐ Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Unknown ☐ Other (Describe):

Immediate Plan Developed: Yes ☐ No ☐ Describe Core Elements: _____
_____
_____

Location of Service: Family Home ☐ Consumer Home/Apt.☐ Provider Facility ☐
Workplace ☐ Hospital ED ☐ Jail ☐ Phone Only ☐
Other ☐ (describe)

Disposition (check all that apply):
Mobile Crisis Activated: Yes ☐ No ☐ ☐ Law Enforcement Involvement
☐ Inpatient Services Voluntary ☐ Inpatient Services Involuntary ☐ Other Medical Care
Consumer/Family Home: ☐ with Supervision/Support ☐ without additional Supervision/Support
Residential Provider: ☐ with Supervision/Support ☐ without additional Supervision/Support
☐ Other (Describe) _____
_____

Provider Collaboration Efforts: Yes ☐ No ☐
If Yes: Initial Planning ☐ Training ☐ Technical Assistance ☐
Post-Event Activities ☐ Revised Plan ☐ Other ☐
Describe:_____
_____
_____
_____
Follow-Up Planned:_____
_____

Crisis Management Note Attached: Yes ☐ No ☐

Signature/Credentials of Person Completing Form_____