

CRISIS PLANNING SHEET

Client's Name: _____ DOB: _____ Weight (lbs/kg) _____

Home Address: _____

Work Address: _____

Phone (Home): _____ Phone (Work): _____ Cellular/Pager: _____

Significant Others:

Name: _____ Phone: _____ City: _____

Name: _____ Phone: _____ City: _____

Relative's name: _____ Phone: _____ City: _____

Relative's name: _____ Phone: _____ City: _____

Primary Therapist:

Name: _____ Phone (Day): _____ Phone (Eve): _____ Pager: _____

Primary Skills Group Therapist (if applicable):

Name: _____ Phone (Day): _____ Phone (Eve): _____ Pager: _____

Back-up therapist (if applicable):

Name: _____ Phone (Day): _____ Phone (Eve): _____ Pager: _____

Pharmacotherapist/M.D (if applicable):

Name: _____ Phone (Day): _____ Phone (Eve): _____ Pager: _____

Case Manager (if applicable):

Name: _____ Phone (Day): _____ Phone (Eve): _____ Pager: _____

MEDICATIONS

___ Date: ___/___/___ Rx: _____ Generic name: _____

M.D.: _____ Phone: _____

Pharmacist: _____ Phone: _____

Daily dose: _____ mg/g/ml No. tabs/caps/ml per day: _____ Dose per tab/cap/syringe: _____ mg/g/ml

Usual no. prescribed: _____ Cautions: _____

Notes/Plans: _____

Date stopped taking/dose changed: ___/___/___ Number tabs/caps/ml remaining: _____

___ Date: ___/___/___ Rx: _____ Generic name: _____

M.D.: _____ Phone: _____

Pharmacist: _____ Phone: _____

Daily dose: _____ mg/g/ml No. tabs/caps/ml per day: _____ Dose per tab/cap/syringe: _____ mg/g/ml

Usual no. prescribed: _____ Cautions: _____

Notes/Plans: _____

Date stopped taking/dose changed: ___/___/___ Number tabs/caps/ml remaining: _____

___ Date: ___/___/___ Rx: _____ Generic name: _____

M.D.: _____ Phone: _____

Pharmacist: _____ Phone: _____

Daily dose: _____ mg/g/ml No. tabs/caps/ml per day: _____ Dose per tab/cap/syringe: _____ mg/g/ml

Usual no. prescribed: _____ Cautions: _____

Notes/Plans: _____

Date stopped taking/dose changed: ___/___/___ Number tabs/caps/ml remaining: _____

Date: ____/____/____ Rx: _____ Generic name: _____

M.D.: _____ Phone: _____

Pharmacist: _____ Phone: _____

Daily dose: _____ mg/g/ml No. tabs/caps/ml per day: _____ Dose per tab/cap/syringe: _____ mg/g/ml

Usual no. prescribed: _____ Cautions: _____

Notes/Plans: _____

Date stopped taking/dose changed: ____/____/____ Number tabs/caps/ml remaining: _____

Date: ____/____/____ Rx: _____ Generic name: _____

M.D.: _____ Phone: _____

Pharmacist: _____ Phone: _____

Daily dose: _____ mg/g/ml No. tabs/caps/ml per day: _____ Dose per tab/cap/syringe: _____ mg/g/ml

Usual no. prescribed: _____ Cautions: _____

Notes/Plans: _____

Date stopped taking/dose changed: ____/____/____ Number tabs/caps/ml remaining: _____

Date: ____/____/____ Rx: _____ Generic name: _____

M.D.: _____ Phone: _____

Pharmacist: _____ Phone: _____

Daily dose: _____ mg/g/ml No. tabs/caps/ml per day: _____ Dose per tab/cap/syringe: _____ mg/g/ml

Usual no. prescribed: _____ Cautions: _____

Notes/Plans: _____

Date stopped taking/dose changed: ____/____/____ Number tabs/caps/ml remaining: _____

3. Recommended crisis intervention plan:

Please Note: As a general rule, I favor continuing my clients in outpatient therapy rather than inpatient treatment (hospitalization).

- Potential risk Factors (e.g., problems with physical health, isolation, homelessness):

- Problematic emotions related to crisis behavior:

- Recommended treatment suggestions (e.g., things that you can do or things that have been helpful to you in the past that may alleviate crisis behavior):
