[Insert Early Psychosis Program Name] **FAX to _____ at _____**

Effective Date_____

CRISIS PLAN

CLIENT INFORMATION

Name_____ Date of Birth_____

County of Residence_____ Phone_____

Emergency contact _____ Phone_____

MEDICAL INFORMATION

Counselor/case manager_____ Phone_____

_____ Phone_____

Provider Agency _____ Phone_____

MH Prescriber_____ Phone_____

Primary Care Physician_____ Phone_____

Person who has a list of current medications_____

Medications that have been helpful in emergencies _____

Allergies/severe medication issues_____

_____

Mental health conditions_____

_____

_____

Substance u se issues_____

_____

_____

Other medical conditions_____

_____

Most recent psychiatric hospitalization: Where?_____

Date_____ Reason_____

_____

CRISIS PLANNING

When I'm ok, I _____

When I'm in crisis, I _____

In the past I've tried (give date and results of effort)_____

What helps when I'm in crisis _____

What doesn't help_____

Agreements and recommendations:

☐ I would like to request a trauma survivor peer support volunteer.

This information can be shared with the following people and agencies to help me in an emergency

_____ _____

_____ _____

_____ _____

_____

Signed Date

_____

Signed Date

Oregon state law allows healthcare providers to share your confidential information to the extent necessary to help you during an emergency. *Oregon Revised Statutes 179.505 (4)(a)*