

CRISIS PREVENTION AND INTERVENTION PLAN

Date of Initial Crisis Plan (mm/dd/yyyy):		Date of Last Revision (mm/dd/yyyy):		Medicaid ID #:	Record #:	
Name:				Date of Birth (mm/dd/yyyy):		
Address:				Telephone Number:		
Clinical Home/First Responder:		Emergency Phone #:		Alternate Phone #:		
LME-MCO:		LME-MCO Phone #:		County:		
Living Situation						
Living Situation (Stable, Unstable):		If "Unstable" Describe:				
In a crisis, assistance will be needed in the following areas (if not applicable, leave blank)						
Children (if yes, indicate ages):	Pets (Yes/Blank):	Transportation (Yes/Blank):	Other (Describe the type of assistance needed):			
Explain what help will be needed:						
Employment (In a crisis, assistance will be needed to contact my employer)						
Assistance will be needed (Yes/No):		Contact Name:		Contact Phone #:		
Please inform them:						
Communication			Preferred Language			
Method (Verbal, Nonverbal, Picture System, Gestures, Sound/Gestures, Other Device):		Preferred Language (English, Spanish, Sign Language, Other):		If "Other", specify:		
Legally Responsible Person						
Guardian Appointed (Yes/No):	Legally Responsible Person Name:			Contact Phone #:		
Insurance						
Type of Insurance:	Name of Company or Payer (If Type is Private or Other):			Policy Number/Member ID:		
Diagnoses						
DSM Code:	Diagnosis:			Diagnosis Date (mm/dd/yyyy):		
Current Medications (Update/revise anytime there is a change)						
Medication Name:	Dose:	Frequency:	Reason for Change:	Date:	Prescribing MD:	Pharmacy:
Allergies (Medication(s) and reaction - Update/revise anytime there is a change)						
Poorly Tolerated Medications (Medication(s) and reaction - Update/revise anytime there is a change)						
Medical/Dental Concerns						

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(Note: The fields above should auto-fill with data you entered on Page 1. If they do not auto-fill, please enter by hand.)			

Supports For The Individual

Notification

List the individuals that should be called in the event of a crisis, indicate the calling order, provide contact information, and indicate if a consent to release information to that person exists.

Calling Order	Who	Agency	Name	Address	Phone #	Is there a valid consent to release (Yes/No)?
	Guardian/ Legally Responsible Person					
	Family Contact 1					
	Family Contact 2					
	Family Contact 3					
	Service Provider					
	Residential Program					
	Care Coordinator					
	Primary Therapist					
	Primary Care Physician					
	Psychiatrist					
	Other Physician					
	Peer Support Specialist					
	Other Support					
	Other Support					

Crisis Follow Up Planning

(Include contact number(s) if not provided above)

	Name	Contact #	Contact #
Who is the primary contact to coordinate care if the individual requires inpatient or other specialized care?			
Who will visit the individual while hospitalized? (This information should come from the individual and reflect the individual's preference)			
	Name	Timeframe	
Who will lead a review/debriefing following a crisis? Within what timeframe?			

Additional Planning Documents

(Indicate if the individual has any of the following documents. If "Yes", attach the document to the Crisis Plan)

	Yes/No	Notes
Individual Behavior Plan		
Suicide Prevention and Intervention Plan		
WRAP Plan		
Futures Plan (youth in transition/young adult)		
Psychiatric Advance Directive (PAD). A PAD is a legal document allowing a consumer to direct his or her psychiatric treatment in the event that he or she becomes unable to make or communicate decisions about that treatment. To find out more information about PADs in North Carolina, go to http://www.nrc-pad.org/states/north-carolina-resources .		
Other Advance Directive or Living Will		

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General Characteristics/Preferences - as described in the individual's own words

What am I like when I am feeling well? Describe what a good day looks like for this person. Provide examples of how s/he interacts, behaves, appears and feels when s/he has an overall sense of wellness and wellbeing.

What are some events or situations that have caused me trouble in the past? Outline significant events that may create or increase stress and trigger the onset of a crisis. (Examples include: anniversaries, holidays, noise, change in routine, inability to express medical problems or to get needs met, out of medication, being isolated, etc.)

What are the early warning signs that I am not doing well? What will others notice about my behavior, speech, and actions when I am not doing well? Describe what others observe when s/he is entering a crisis episode. Include lessons learned from previous crisis events. (Examples include: not keeping appointments, isolating himself, loud or hyper-verbal speech, not sleeping well, eating too much, etc.)

How can others help me and what can I do to help myself to address a crisis early on? Who is best able to assist me? Describe prevention and intervention strategies that have been effective in reducing stress, problem solving, and keeping the person from needing higher levels of care such as a trip to an emergency department or crisis center or inpatient hospitalization. (Examples include: breathing exercises, journaling, taking a walk, listening to music, calling a friend or family member or provider, etc.)

If I am in crisis, what are ways that others can help me and how can I help myself? What strategies do not work well for me? List everything that has worked well for the person in the past. Focus first on the least restrictive steps including natural and community supports. Describe how crisis staff should interact with the person in crisis. Describe preferred and non-preferred medications, treatment facilities, and options for respite. Include the person's preferred process for obtaining back-up in case of emergency. (Examples include: I like music, I like to go for a walk, I like to be talked to, call my sponsor, remind me of my PRN meds, I don't like to be talked to, I don't like to be touched, I prefer ABC hospital over XYZ hospital, etc.)