

ABOUT THIS FORM: Print out this form and fill it out in handwriting. Or type in the light blue highlighted fields and print out the completed form. This form cannot be saved to the computer. The light blue color will not show when the form is printed.

Mid-Valley Behavioral Care Network

Effective Date _____

Share with your mental health provider and **FAX to Roger at 503-585-4989 (for PCC file)**

PERSONAL ACTION / CRISIS PREVENTION PLAN

CLIENT INFORMATION

Name _____ Date of Birth _____

County of Residence _____ Phone(s) _____

Support Persons: (family, advocate, peer support)

✕ Mark who you want called in a crisis

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

MEDICAL INFORMATION

Counselor / Case Manager _____ Phone _____

Agency _____ Phone _____

If you are taking mental health medications, who prescribes them?

Name _____ Phone _____

Primary Care Physician _____ Phone _____

Person who has a list of your **current** medications _____

Medications that have been helpful in emergencies _____

Medications to avoid and why _____

Allergies / adverse medical effects _____

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Mental health conditions _____

Substance use issues _____

Medical conditions _____

I have completed a *Declaration for Mental Health Treatment*. It is available at: _____

**PERSONAL ACTION / CRISIS
PREVENTION PLANNING**

The document called "Ideas to Help Spark Your Thinking" has suggestions others have found helpful.

1. Some things I want from my life are: _____

2. Signs that I'm doing OK: _____

3. Early signs that I'm not feeling well: _____

4. What I can do to help myself: _____

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5. Ways that others can help me: _____

6. What I don't want – What doesn't help: _____

7. I know I need to get help when: _____

In a crisis I need to know I have help with: Pets Children Transportation

Other: (explain) _____

In a crisis situation, I will do this: _____

Optional: My provider or other support person agrees to do this: _____

I would like to request a trauma survivor peer support volunteer (if you're on Oregon Health Plan)

I would like information about other peer support services

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)*