PERSON DIRECTED CRISIS PREVENTION PLAN

Create with your MH provider or crisis worker and FAX to Stephanie Vieu, MVBCN 503-585-4989

INDIVIDUAL INFORMATION

Name: _____Date of Birth: _____

County of Residence: _____ Phone(s): _____

Support Person(s) (family, advocate, peer support):

Name:	Relationship:	Phone:
_____	_____	_____
Name:	Relationship:	Phone:
_____	_____	_____
Name:	Relationship:	Phone:
_____	_____	_____

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

1. What a usual day looks like for me: _____
_____
_____
_____

2. How I know that I'm not feeling well: _____
_____
_____
_____

3. What I want to hear from someone else at this point: _____
_____
_____
_____

4. Things that someone can do to help me: _____
_____
_____
_____

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

6. What I can do that helps: _____
_____
_____
_____

In a crisis I need to know I have help with: ☐ Pets ☐ Children ☐ Transportation
☐ Other (explain): _____

Who are my safe people? _____

What is my safe place? _____

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 crisis or emergencies: _____
_____

Medications to avoid and why: _____
_____

Allergies / adverse medical effects: _____
_____

Mental health conditions: _____
_____

Substance use issues: _____
_____

Medical conditions: _____
_____
_____

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

As an Oregon Health Plan Member, I understand that medical and mental health provider's work together to provide my care. I understand that this Plan may be shared with those who may be assisting me in times of crisis. These include Psychiatric Crisis Center, hospital emergency room, and my primary care provider. _____ _____
Signature of individual and/or parent/guardian *Date*