Youth Crisis Plan

Name: _____ **Date of birth**: _____ **Date(s) of Plan**: _____

Team Members Participating in Plan Creation: _____

1. **Crisis Behavior We're Trying to Prevent:** _____

_____

2. **How do I know I am Having a Good Day?** _____

_____

3. **Crisis Plan Goal:** _____

_____

4. **Measurement Strategy:** _____

_____

Common Triggers:	Daily Prevention Strategies:	Who is responsable?	Due by: (if applicable)

I understand that medical and mental health provider's work together to provide care for Oregon Health Plan Members. I understand that this Plan may be shared with those who may be assisting in times of crisis. These include Psychiatric Crisis Center, hospital emergency room, and my primary care provider.

_____ _____ _____

Signature of youth *Parent or guardian* *Date*

Youth Crisis Plan

Name: _____ **Date of Birth**: _____ **Date(s) of Plan**: _____

Parent(s) Name: _____ **Name of Clinician:** _____

Who's on My Team: _____

Diagnosis: _____ **Medical Condition:** _____

How I Know I'm Going Into Crisis (Triggers/Early Warning Signs): **Yes No** **Allergies:** _____

1. **How I Know I'm Going Into Crisis** (Triggers/Early Warning Signs): _____

_____

2. **What I Need When I'm in Crisis** (Early Intervention & Intervention Strategies): _____

_____

3. **What I Need When My Child is in Crisis:** _____

_____

4. **What I don't Need** (Youth & Parent- Things that have been tried in the past that were not helpful): _____

_____

5. **Who is Most Helpful When I'm in Crisis** (include contact information): _____

_____

6. **What One Thing Could Help Me or My Child Right Now:** _____

_____

Ways I Can Remain Safe:

1. _____
2. _____
3. _____
4. _____
5. _____