PERSON DIRECTED CRISIS PREVENTION PLAN - Adult

Fax to Psychiatric Crisis Center 503-585-4965

INDIVIDUAL INFORMATION

Name _____Date of Birth _____

County of Residence _____ Phone(s) _____

Support Persons: (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: _____
_____
_____

PERSON DIRECTED PREVENTION PLAN

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 providers 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*