Fax to Psychiatric Crisis Center 503-585-4965

Youth Crisis Prevention Plan

Name: **DOB**: **Date(s) of Plan**:

Team Members Participating in Plan Creation:

Crisis Behavior We're Trying To Prevent:

How Do I Know I am Having a Good Day?:

Crisis Plan Goal:

Measurement Strategy:

Prevention Steps:

Common Triggers:	**Daily Preventative Strategies**:	**Who is responsible**:	**Due by:** (if applicable)

I understand that medical and mental health providers 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*

Fax to Psychiatric Crisis Center 503-585-4965

Youth Crisis Intervention Plan

Name: **DOB**: **Date of Plan**:

Parent(s) Name: Name of Clinician:

Who's On My Team:

Diagnosis: Medical Condition:

Currently Prescribed Psychotropic Medication: Yes No Allergies:

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

What I Need When I'm in Crisis (Early Intervention & Intervention Strategies):

What I Need When My Child is in Crisis:

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

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

What One Thing Could Help Me or My Child Right Now?

Ways I Can Remain Safe:
1.
2.
3.
4.
5.