CLINICAL CRISIS RECOMMENDATIONS

Client Name/ID (or affix label): _____

1. Which of the following legal documents apply to consent to treatment?
   Advance Directive: ☐ No ☐ Yes
   Legal guardian: ☐ No ☐ Yes – If yes, who? _____
   How do we contact them? _____ (*Legal Guardian is someone that has authority to consent/give authorization for medical treatment)*
   Power of Attorney: ☐ No ☐ Yes
2. Friend/natural support (Name/phone number): _____
3. Are there any children/pets in the home that need care? _____
4. Behavioral Health Provider Agency: _____
5. Medical Primary Care Provider: _____
6. Medical Issues: _____
7. Co-Occurring Issues: _____

Baseline Behaviors	**Strength**	**No Impairment**	**Some impairment**	**Significant Impairment**
Self-care skills:	☐	☐	☐	☐
Stability of living situation:	☐	☐	☐	☐
Availability of supportive friends/family:	☐	☐	☐	☐
Social behaviors:	☐	☐	☐	☐
Cognitive functioning:	☐	☐	☐	☐
Ability to keep self safe:	☐	☐	☐	☐
Capacity to handle stress/change	☐	☐	☐	☐
Impulse control/Judgment	☐	☐	☐	☐
Insight	☐	☐	☐	☐
Hallucinations/Delusions		☐	☐	☐

Which of the following ***potential risk factors*** *currently apply for this client (check all that apply, and address below):*

☐ Suicidal (history of prior suicide attempts)
☐ Self-harm Behavior
☐ Running away
☐ Homelessness
☐ History of trauma/victimization
☐ Multiple residential placements *(foster homes, Adult Family Homes, etc.)*
☐ Other *(describe)* _____
☐ Adherence Concerns with Medication
☐ History of aggression
☐ Physical Disability/other medical condition
☐ Family History (Suicide/psychiatric disorders)
☐ Stressors/triggering events

Explanation of Risk Factors checked above:

_____

_____

_____

What protective factors are present? (Internal/External) _____

_____

What interventions have historically been successful or likely to be successful in managing crises?

_____

What intervention strategies should be considered prior to inpatient care?

_____

_____ _____

Primary Clinician *(Print name and credentials)* Date

Clinical Crisis Recommendations **reviewed on this date and NO CHANGES were necessary; information is still current and accurate.**
Date: _____ Initials: _____ clinician
Date: _____ Initials: _____ clinician
Date: _____ Initials: _____ clinician

Clinical Crisis Recommendations **reviewed on this date and it was REVISED (if further revisions are needed, a new form should be used)**
Date: _____ Initials: _____ clinician
Submit to Data Entry after revised
Data Entry completed: _____/_____/_____(Date) _____ (Initial)