MENTAL HEALTH CRISIS REPORTING FORM

ADULTS : KITTSON, NORMAN, MAHNOMEN, MARSHALL, PENNINGTON, POLK, ROSEAU, & RED LAKE COUNTIES
CHILDREN: KITTSON, NORMAN, MAHNOMEN, MARSHALL, POLK, & RED LAKE COUNTIES

CONTACT DATA:

Agency Completing Form:		Staff Completing Form:	Contact Date(s):
CHECK ALL THAT APPLY:	☐	PHONE CONTACT WITH CLIENT	CONTACT TIME (15 min.):
	☐	FACE-TO-FACE CONTACT WITH CLIENT: Assessment: + Intervention + Stabilization =Contact Time	CONTACT TIME (15 min.):
	☐	CONSULTATION WITH PROFESSIONALS (Phone or face-to-face) Who:	CONTACT TIME (15 min.):
	☐	TRANSPORTATION (time with & without client) From: To:	CONTACT TIME (15 min.):
FACE-TO-FACE CONTACT LOCATION	☐Client's Residence ☐Crisis Team Office ☐Other Mental Health Provider ☐Public Location ☐Private Residence ☐Homeless Shelter ☐E.D. / Hospital ☐Other:		
PRIMARY REFERRAL SOURCE:	☐Self, family, friend ☐Health Plan ☐Probation Officer ☐Primary care physician ☐School ☐Law Enforcement ☐Hospital ☐Community Mental Health Provider/ Case Manager ☐Residential treatment or foster care provider ☐Unknown ☐Other (describe):		

CLIENT DATA:

Name (if given):	Date of Birth:	County of Responsibility:
Social Security Number:	Gender: ☐Male ☐Female ☐ Other	MH Crisis Plan Available: ☐Yes ☐ No ☐Unknown
Place/Phone Number to Reach Client at Time of Referral:		Client Phone Number/s (if different):
Client Address:		

***Complete the following for MINORS only (17 & under): If over 17 proceed to* "Incident Data"**

Select One: ☐ 911 ☐ Face-to-Face Immediate ☐ Face-to-Face within 24 Hours ☐ Phone Consult Only ☐ Referral Only

RACE: ☐ White ☐American Indian or Alaskan Native ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐Asian ☐Unknown ☐Other race (list):

ETHNICITY: ☐Latino or Hispanic ☐Hmong/Laotian ☐Somali ☐None ☐Other (list):

LANGUAGE AT HOME: (primary only): ☐English ☐Hmong ☐Spanish ☐Somali ☐Other (list):

HOSPITALIZATION in past year: ☐Yes ☐No ☐Unknown | RESIDENTIAL TREATMENT in past year: ☐Yes ☐No ☐Unknown

INCIDENT DATA:

☐ Suicidal (ideation)	☐ Suicidal (attempt)	☐ Self-Injurious Behaviors (non-suicidal)
☐ Anxiety/Panic	☐ Trauma (assault, loss, abuse)	☐ Aggressive, threatening, or homicidal behaviors
☐ Depression	☐ Situational Crisis	☐ Challenging, disruptive, out of control behavior
☐ Mania	☐ Psychotic or delusional (no threatening behaviors, non-assaultive)	

☐ Other (MUST describe, e.g., grief, parenting concern, substance abuse) :

Current Stressors/Nature of Problem/Current Symptoms/Risk Behaviors/Problems:

Known or suspected alcohol/drug abuse at time of assessment? ☐Yes ☐No
Prescription Medication(s) Known:

OUTCOME:

Brief Description of Outcome:

Client Whereabouts Known at Episode Closing? ☐Yes ☐No

Complete the following for MINORS only (17 & under)

Immediate Disposition:
- ☐ Hospitalization
- ☐ Shelter Placement
- ☐ Emergency Foster Care
- ☐ Temporary residence with relatives/friends
- ☐ Remained in current home
- ☐ Other (MUST specify):

Coordination (All that Apply)
- ☐ With Case Manager
- ☐ With CTSS Provider
- ☐ Other (list):

Complete the following for ADULTS only (18 & older)

Referrals Made *(new services you arranged, not services in place):*
- ☐E.D./Psychiatric Hospital
- ☐Residential Treatment
- ☐Physician/Psychiatrist/CNS
- ☐Additional Mental Health Services
- ☐Chemical Health Services
- ☐Other (Must Specify):

Case Management
- ☐Not Receiving, Appoint.Arranged
- ☐Already Receives, Sharing Info
- ☐Not Receiving, Referral Declined
- ☐Already Receives, NOT Sharing Info
- ☐Not Receiving, Not Referred

Staff Signature _____ Date _____ County Director Signature/Approval _____ Date _____

***PLEASE SEND FORM TO THE CRISIS COORDINATOR AT NWMHC 603 BRUCE ST. CROOKSTON, MN 56716 FOR PROCESSING**

Rev. Jan. 2010

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CHILDREN: KITTSON, NORMAN, MAHNOMEN, MARSHALL, POLK, & RED LAKE COUNTIES

COMPLETE THIS PAGE ONLY FOR CHILDREN (17 & UNDER) RECEIVING STABILIZATION SERVICES:

Name (if given):	Date of Birth:	County of Responsibility:
Contact Date:		

***IF STABILIZATION SERVICES WERE PROVIDED FOR AN INDIVIDUAL AGED 0-17, PLEASE COMPLETE THE FOLLOWING:**					
CASII Score:			**SDQ Scores: Parent Self Teacher/Case Manager**		
Other Services (all that apply)	**Current**	**Referrals**	**Other Services** (cont)	**Current**	**Referrals**
Individual Psychotherapy	☐	☐	Residential Treatment	☐	☐
Group Therapy	☐	☐	Case Management (Children's Mental Health)	☐	☐
Family Psychotherapy	☐	☐	Medication management – Psychiatrist	☐	☐
Individual Skills Training	☐	☐	Medication management – Primary care provider	☐	☐
Group Skills Training	☐	☐	Partial hospitalization	☐	☐
Family Skills Training	☐	☐	Inpatient hospital services	☐	☐
Mental Health Behavioral Aide	☐	☐	Support groups	☐	☐
Day Treatment	☐	☐	None/unknown	☐	☐

_____ _____
Staff Signature Date