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: | Provisional Diagnosis: ICD9 Code

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)		Complete the following for ADULTS only (18 & older)	
Immediate Disposition:	Coordination (All that Apply)	Referrals Made *(new services you arranged, not services in place):*	Case Management
☐ Hospitalization ☐ Shelter Placement ☐ Emergency Foster Care ☐ Temporary residence with relatives/friends ☐ Remained in current home ☐ Other (**MUST** specify):	☐ With Case Manager ☐ With CTSS Provider ☐ Other (list):	☐E.D./Psychiatric Hospital ☐Residential Treatment ☐Physician/Psychiatrist/CNS ☐Additional Mental Health Services ☐Chemical Health Services ☐Other (Must Specify):	☐Not Receiving, Appoint.Arranged ☐Already Receives, Sharing Info ☐Not Receiving, Referral Declined ☐Already Receives, NOT Sharing Info ☐Not Receiving, Not Referred

Staff Signature ______ Date ______ Supervisor Signature ______ Date ______

Client Signature (☐Refusal/Reason above) ______ Date ______ County Director Signature/Approval ______ Date ______

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

Rev.July. 2011

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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