

## Cross System Crisis Plan

TODAY'S DATE	CLIENT'S NAME	DATE OF BIRTH
MENTAL HEALTH AGENCY		TELEPHONE NUMBER
MENTAL HEALTH AGENCY CASE MANAGER		TELEPHONE NUMBER
LEGAL REPRESENTATIVE / NSA NAME (Specify relationship)		TELEPHONE NUMBER
RESIDENTIAL SUPPORT AGENCY NAME	TELEPHONE NUMBER	ON-CALL NUMBER
DDA CASE MANAGER/SOCIAL WORKER		TELEPHONE NUMBER
DDA MENTAL HEALTH LIAISON		TELEPHONE NUMBER
<b>MH and Medical Diagnosis (DSM-5 Format)</b>	CONTRACT THERAPIST	TELEPHONE NUMBER
	DOC CONTACT	TELEPHONE NUMBER
	EMPLOYMENT/VOCATIONAL / SCHOOL CONTACT	TELEPHONE NUMBER
	FAMILY CONTACT	TELEPHONE NUMBER
	GENERAL PHYSICIAN / PRESCRIBER	TELEPHONE NUMBER
	MH CRISIS TELEPHONE NUMBER	DDA IR FAX NUMBER
<b>COMMUNICATION</b> <input type="checkbox"/> Nonverbal <input type="checkbox"/> Verbal <input type="checkbox"/> Gestures <input type="checkbox"/> Picture System <input type="checkbox"/> Sound and Gestures <input type="checkbox"/> Other Device:		<b>PREFERRED LANGUAGE</b> <input type="checkbox"/> English <input type="checkbox"/> Sign Language <input type="checkbox"/> Spanish <input type="checkbox"/> Other:
<b>Challenges</b>		
VISION	HEARING	
MOBILITY	EATING / SWALLOWING	
<b>Contact for Updated Medication List</b>		
NAME		TELEPHONE NUMBER
<b>Risk Issues (For each box checked, briefly describe)</b>		
<input type="checkbox"/> Allergies (Food, Medication, Other):  <input type="checkbox"/> Medical Conditions:  <input type="checkbox"/> Suicidal Ideation/Gestures:		

- Aggression:
  
- Eludes Supervision:
  
- Sexual:
  
- Fire Setting:
  
- Substance Abuse:
  
- Legal Issues:
  
- Other:

Symptom / Behavior Description	Response(list interventions; when and who should be called; scripts; for what purpose)

Signatures (Legal representative, NSA, residential program staff, DDA staff, mental health agency, other)			
SIGNATURE	DATE	PRINTED NAME	TELEPHONE NUMBER

Review and Update (if plan requires significant revision, please complete new plan)		
COMMENTS / CHANGES	DATE	SIGNATURE