DIVISION OF BEHAVIORAL HEALTH
EMERGENCY SERVICE CONTACT

☐ **Crisis Intervention** ☐ **Crisis Stabilization** **Clear Form**

Emergency Services Contact Profile

Contact Date: _____ Case/Record Number: _____

Patient Name: _____ DOB: _____ Medicaid ID: _____

Address: _____ Insurance ID: _____

Start Time: _____ Stop Time: _____ Duration: _____

Service Provider: _____

Location:

☐ By Appointment ☐ Community Service Patrol ☐ Drop-in / Office ☐ Emergency Outreach intervention
☐ Hospital / On-call intervention ☐ Phone ☐ In Home ☐ In Community
If Other, Specify:

Symptoms Related to Complaint:

☐ Anxiety
☐ Depression
☐ Suicidal
☐ Homicidal
☐ Substance Abuse related
☐ Unknown
If Other, Specify:

Psychosocial/Environmental Features:

☐ Problems with primary support groups
☐ Problems related to the social environment
☐ Educational problems
☐ Occupational problems
☐ Housing problems
☐ Economic problems
☐ Problems with access to health care services
☐ Problems related to interaction with the legal system/crime
☐ Other Psychosocial and Environmental problems
If Other, Specify:

Presenting Risk:

☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all ☐ Not present ☐ Unknown

Presenting Problem (Nature of Crisis):

Assessment (Recipient's mental, emotional & behavioral status/functioning in relation to crisis. Include multiaxial diagnosis/mental status exam (if appropriate) and service/treatment recommendations):

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Treatment Plan (Describe prescribed and recommended services and interventions):

Services (Describe services and interventions provided by the clinician and/or Behavioral Health Clinic Associate):

Follow-Up Disposition (Describe the final resolution and/or arrangements resulting from the intervention ex. referred to self and/or others; referred for treatment, hospitalized, etc.):

Clinician:	Signature and Credentials	Date
Behavioral Health Clinic Associate: (if applicable)	Signature and Credentials	Date