NATIONAL Center on Domestic Violence, Trauma & Mental Health

Responding to Domestic Violence: Sample Forms for Mental Health Providers*

2004

*This document was adopted from adapted from DVMHPI-CDPH-MODV Pilot Project, previously approved by OVW for 2004 Disabilities Grant. Also see, Responding to Domestic Violence: Tools for Mental Health Providers (National Center, 2004).

ASRI Pilot Project Forms

CONTENTS

DV/Mental Health Safety Risk Assessment & Disposition
Form 1.1, Page 1/2

Client Identification _____ Date_____

SAFETY RISK

- **Safety Risk Identified ____Yes _____No**
- **DV Risk positive ____Yes _____No**
  - **Level of DV Risk: ____High ____Medium ____Low ____N/A**
- **Mental Health Risk positive: ____Yes _____No**
  - **Level of Mental Health Risk: ____High ____Medium ____Low ___N/A**
- **Other Safety Risk: ____Yes _____No**
  - **Level of Other Safety Risk: ____High ____Medium ____Low ___N/A**

INTERVENTIONS AND DISPOSITION

- **911 called: _____by Client ____by MHC ____N/A**
- **Initial Safety Plan Discussed: ____Yes _____No ____N/A**
- **Referred to DV Help Line: ____Yes _____No ____N/A**
- **Referred to DV Partner Agency: ____Yes _____No ____N/A**
- **Referred to ER or Psychiatric Hospital: ____Yes _____No ____N/A**
- **Referred for CMHA: ____Yes _____No**
- **Assigned to Designated Pilot Therapist: ____Yes _____No**

Intake Form: DV/Mental Health Safety Risk Assessment & Disposition
Form 1.1, Page 2/2

DV & MH RISK	Immediate DV	High DV	Moderate DV	Low DV
Immediate MH				
High MH				
Moderate MH				
Low MH				

Signature _____

Date _____

Record of Domestic Violence & Trauma Assessment and Intervention
Form 1.2, Page 1/1

Client Identification_____**Date**_____

Provider Name_____

Domestic Violence Indicators:

- ❑ Possible DV based on intake screening Date_____
- ❑ DV identified during Comprehensive MH Assessment Date_____
- ❑ DV identified during course of treatment Date_____
- ❑ CMHA DV Screen (Form XXX) completed Date_____
- ❑ CMHA Danger assessment (Form XXX) completed Date_____
- ❑ CMHS Comprehensive DV Assessment (Form XXX) completed Date_____
- ❑ Follow-up questions about safety and DV Date_____

Domestic Violence Interventions

- ❑ Initial Safety Measures Discussed (intake?) Date_____
- ❑ Referred to Pilot Project Clinician Date_____
- ❑ Referred to Domestic Violence Partner Agency Date_____
- ❑ Referred to DV Help Line Date_____
- ❑ Information provided Date_____
- ❑ Safety Plan Created Date_____

Lifetime Trauma Indicators

- ❑ During Comprehensive MH Assessment Date_____
- ❑ Through Trauma Screening Tool Date_____
- ❑ During course of treatment Date_____

Lifetime Trauma Treatment/Interventions

- ❑ Addressed immediate safety issues Date_____
- ❑ Established therapeutic relationship Date_____
- ❑ Identified client strengths Date_____
- ❑ Addressed client's ability to manage feelings/affect regulation Date_____
- ❑ Addressed intrusive recollections of trauma Date_____
- ❑ Addressed numbing, avoidance, dissociation Date_____
- ❑ Addressed hyperarousal symptoms Date_____
- ❑ Addressed other self-capacities, frame of reference, beliefs and needs Date_____
- ❑ Baseline TREP/CSDT Assessment Date_____
- ❑ Follow-up TREP/CSDT Assessment Date_____

Initial DV Screening and Assessment
Form 2.1, Page 1/2

Framing Questions

- I don't know if this has happened to you, but because so many people experience abuse and violence in their lives, it's something I always ask about. Is there anyone in your life right now who makes you afraid?
- I wonder if some of what you are experiencing may be related to how you are being treated at home
- I understand from what you said during your intake interview that you are concerned about the way your partner is treating you; you are concerned about your safety at home….

Screening Questions

Physical abuse

- **Has your partner ever physically hurt or threatened to hurt you or someone you care about?** (e.g. hit, slapped or kicked you, thrown something at you, held you against your will?) Yes____ No___
  - If yes, who did this to you? _____
  - When did this happen?_____ Where_____ Is it still going on? Yes___ No___

Psychological abuse

- **Has your partner tried to undermine or control you in other ways by what he/she says or does?** Yes ___No___
  - If yes, who did this to you? _____
  - When did this happen?_____ Where_____ Is it still going on? Yes___ No___

Sexual abuse

- **Has your partner ever used sexuality to harm or control you or forced you to engage in sexual activities when you didn't want to?**
  - If yes, who did this to you? _____
  - When did this happen?_____ Where_____ Is it still going on? Yes___ No___

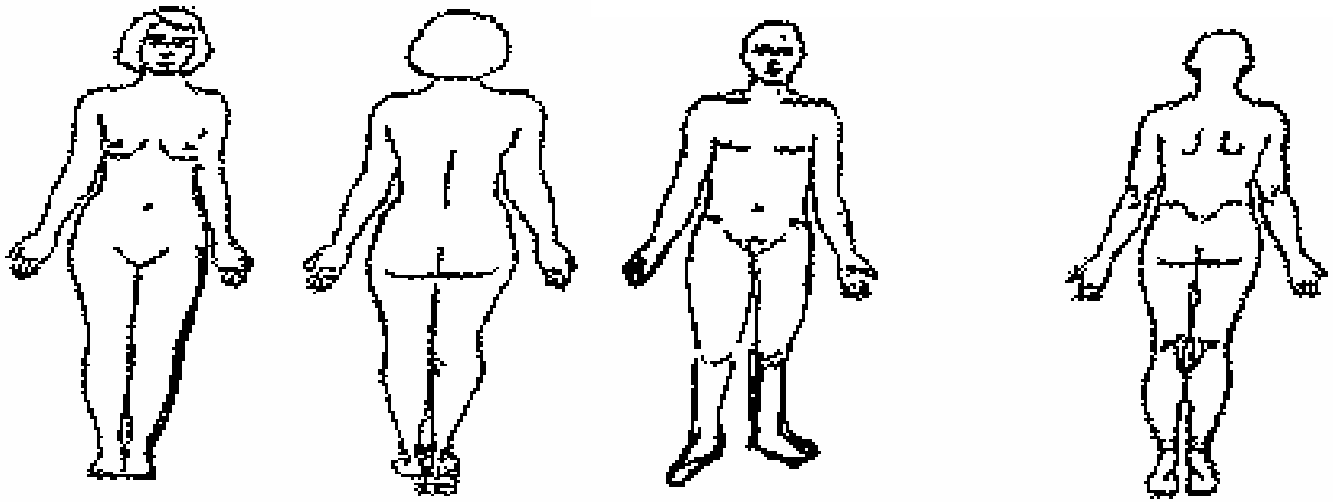
Other abuse

- **Has your partner ever done other things to harm or control you?**
- **Are you afraid of him/her?** Yes ___No___
- **Has anyone else tried to make you afraid?** Yes___ No___
  - If yes, who did or is doing this? _____
  - When did this happen?_____ Where_____ Is it still going on? Yes___ No___

Initial DV Screening and Assessment
Form 2.1, Page 2/2

Document description, size and location of injuries on body map: Mark Injuries using the scale below.

1 = Threats of abuse or use of weapon
2 = Slapping, pushing, no injuries or lasting pain
3 = Punching, kicking, bruises, cuts and/or continuing pain
4 = Beating up, severe contusions, burns, broken bones
5 = Head injury, internal injury, permanent injury
6 = Use of weapon; wound from weapon



Description of abuse in client's own words, including: what has happened, how long it's been going on, whether or not client was pregnant or weapons were used, name of and relationship to perpetrator, date, time of day, location of abusive incidents, any injuries or mental health symptoms that resulted from the abuse the abuse, injuries requiring medical treatment or hospitalization, most recent episode, most severe, pattern and frequency, whether or not it's getting worse:

Observations of client's demeanor or physical indications of abuse:

Domestic Violence Danger Assessment Form
Form 2.2, Page 1/2

Comprehensive Mental Health Assessment Chart

Immediate Danger

- ❑ Are you in immediate danger? Yes___ No___
  Is your partner here in the building (if applicable)? Is he/she likely to return? Yes___ No
  Do you think he/she is dangerous? Does he/she have a weapon? Yes___ No___

- ❑ What do you feel would be the safest thing to do right now? What would you like to do?
  - ❑ Would you like me to call the police? Yes___ No___
  - ❑ Do you have an order of protection? Yes___ No___
  - ❑ Do you want to go home with your partner? Yes___ No___
  - ❑ Do you have someplace safe to go? Yes___ No___

Danger on Leaving the Mental Health Setting

- ❑ Are you afraid to go home? Yes___No___
  Afraid your life may be in danger? Yes___ No___

- ❑ Are the threats or physical violence becoming more frequent, severe or frightening? Yes___ No___

- ❑ Has your partner become more controlling, making it harder for you to make phone calls or get away? Does he control most of your daily activities? Yes___ No___
  Has he/she been stalking you? Yes___ No___
  Has he threatened to kill you and/or do you think he is capable of killing you? Yes___ No___

- ❑ Does your partner have access to any weapons? Is there a gun in the house? Yes___ No___
  Has he/she used them against you or threatened you with them? Yes___ No___

- ❑ Are you planning to leave your partner? Yes___ No ___
  Does your partner know about your plans? Yes___ No___
  Do violence and threats increase around impending separation Yes___ No___

- ❑ Has there been evidence of severe depression, alcohol or drug binges (uppers) or increasing mental instability (erratic changes in mood or behavior)? Yes___ No ___
  Has he/she threatened suicide or homicide? Yes___ No___

- ❑ Has he/she been violent outside the home? Yes___ No___
  Has your partner injured any animals or pets? Yes___ No___
  Is he violent toward the children? Has this been recent? Yes___ No___

- ❑ What is your partner's profession? Could he/she use it against you (i.e., police officer, lawyer, mental health professional, etc.) Yes___ No___

- ❑ Does your partner have a criminal record? Currently engaged in any criminal activity? Yes___ No___

- ❑ Do you know if he/she was abusive with previous romantic partners? Yes___ No___
  Does your partner feel like he/she owns you. ("If I can't have you, no one will") Yes___ No___
  Is he/she violently jealous and always accusing you of infidelity? Yes___ No___

- ❑ Has your partner forced you to have sex with him/her recently? Yes___ No___

Domestic Violence Danger Assessment Form
Form 2.2, Page 2/2

Danger Assessment [in client's own words, including: level of fear and perceived danger, escalation in frequency, severity, threat, level of control, stalking; partner's access to or use of weapons, increasing mental instability, depression, suicidality (client and perpetrator), drug use; violence outside the home, cruelty to animals or pets, criminal record, violence toward children; coerced sex, pathological jealousy; attempted choking or strangulation; ability to use profession against partner (i.e. police, lawyer, MH professional); partner awareness of plans to leave]

Observations of client's demeanor or physical indications of abuse:

Comprehensive Mental Health Assessment: Client Safety Plan

Chart Form 2.3, Page 1/1

Suggestions for Safety

- ❑ **Abuser poses threat at Mental Health Center**
  - ❑ Call 911
  - ❑ Keep client hidden until she/he can escape (police, shelter, abuser leaves, other)
  - ❑ Client decides to go with partner after making safety plan

_____

_____

_____

- ❑ **Immediate shelter**
  - ❑ Call Help Line or Partner DV agency
  - ❑ Arrange to pick up belongings at safe time or with police escort

_____

_____

_____

- ❑ **Getting order of protection to have abuser removed from home**
  - ❑ Call Help Line or Partner DV agency
  - ❑ Take safety precautions at home (locks, security, lighting)
  - ❑ Identify numbers to call, safe places to go, people to warn
  - ❑ Pack important documents and items
  - ❑ Determine ability to anticipate and leave
  - ❑ Plan for quick escape if abuser returns
  - ❑ Discuss safety with children, inform caretakers about potential for kidnapping
  - ❑ Carry certified copy of Order at all times, inform local police, document guns\
  - ❑ Get cell phone through DV program or City Help Line **1-877-863-6338**
  - ❑ Other

_____

_____

- ❑ **Returning home to partner and/or preparing to leave**
  - ❑ Call Help Line or Partner DV agency
  - ❑ Identify numbers to call, safe places to go, people to warn
  - ❑ Pack important documents and items
  - ❑ Determine ability to anticipate, avoid dangerous locations or leave, protect self and kids
  - ❑ Plan for quick escape
  - ❑ Discuss safety with children, calling police, collect calls, leaving
  - ❑ Increase financial independence, open savings account, obtain credit card, reduce isolation, get cell phone, through DV Program or Help Line **1-877-863-6338**
  - ❑ Other

_____

_____

Comprehensive DV Assessment **Form 2.4, Page 1/2**

Overall Impact of Abuse (in client's own words)

Impact of abuse on client's life: [How partner's behavior affected ability to do the things client wants or needs to do, (e.g. disrupted activities or ability to work, go to school, or maintain contact with friends and family); client assessment of situation, what client would like to see happen, issues or obstacles client faces in achieving those goals, (including cultural, religious, stigma-associated and socioeconomic barriers); resources and sources of support client has that have or could be helpful to her/him]

Impact of abuse on physical health: [Including: injuries, medical problems, pregnancy complications, or hospitalizations due to the abuse or medical conditions that make the client more vulnerable to being abused, effects of abuse on physical health, injuries, hospitalizations, new medical problems or symptoms, partner attempts to control access to treatment, ability to take care of her/himself, ability to take medication properly)

Psychological impact of the abuse: [Including client's feelings about her/himself and situation, emotional impact of the abuse, changes over course of relationship, trauma-related symptoms (e.g. PTSD, Complex PTSD, Dissociative symptoms, self-cutting, high risk sexual activities, substance abuse, somatization, anxiety, panic, depression, eating disorders, ask specifically about suicidality and homicidality (expressing anger/desperation or genuine intent), impact on ability to access mental health treatment, control of meds, threats to commit, coerced overdoses, labeling client as crazy, threatening to use MH issues to take away children]

Impact of abuse on her/his children: [Remember to remind client that what she/he says is confidential unless she/he report any child abuse but if she/he has concerns about the children being abused, you can work with her/him to try to find ways to keep her/him and the children safe. Ask about whether children have witnessed abuse, how the abuse has affected them, what changes she/he has noticed since the abuse began, whether the children have developed any medical, emotional, learning or behavioral problems or psychiatric symptoms that might be related to the abuse. Find out about what concerns the client has about the children's safety, behavior or emotional states)

Comprehensive DV Assessment **Form 2.4, Page 2/2**

Children's Responses to Trauma

- Increased crying, sadness, helplessness, guilt; Fearfulness, clinginess, separation anxiety, stranger anxiety;
- Nightmares, night terrors, difficulty falling asleep or withdrawal into sleep;
- Eating problems, physical complaints;
- Feeling as if events are recurring, sensitivity to loud noises or other reminders of trauma;
- Isolation, withdrawal, lack of interest in play;
- Spacing out, phobic behavior, sense of not having any future;
- Regression to an earlier developmental stage;
- Aggression, tantrums, acting out behavior, oppositional behavior;
- Truancy, school refusal, trouble with school schoolwork, inattentiveness to instructions;
- Repetitive play (of traumatic events), trauma reenactment;
- Hypervigilance, obsession with trauma details;
- Exaggerated startle response.

From Kerig, Fedorwoicz, Brown, Warren (2000).

Coping Strategies [Include what client does to cope, how coping strategies affect client's daily life, what client has tried in the past to protect herself and the children, how that did or did not work, degree of isolation, sources of current or potential support, ways client cares for children, how keeping self and children safe, strengths, capacities and resources. Ask about family, community, culture, religion/spirituality, education, work situation, income, etc. and how they affect current situation, options and choices]

Goals and Strategies [What client's goals are, barriers she/he faces and strategies for overcoming barriers and achieving goals]

TRAUMA ASSESSMENT FORM
Form 3.1, Page 1/2

This form serves as a guide to taking a trauma history. It is recommended for use as part of a comprehensive assessment, but should be carefully paced to client needs and level of distress. After clinical review, this information should be incorporated into the treatment plan, with client participation. It can also be used conjunction with developing an Advanced Directive/Personal Trauma Safety Plan.

1. **Sometimes, people have been hurt or frightened by others in the past.** Some have lived through terrible experiences such as abuse, rape, combat, or injuries. If we know about these experiences, we may be better able to help you. **Are you willing to answer a few questions to help us understand more about your personal experience with such things?**

   (If the client is unwilling, or uncertain whether to proceed, please gently explore the basis for his or her refusal and attempt to address any concerns about the process).

2. H**ave you ever been physically hurt or threatened by another?** (e.g., hit, punched, slapped, kicked, strangled, burned threatened with object or weapon, etc.)? ☐ **Yes** ☐ **No**

   If yes, in the past?___ Is it still going on?___ Are you able to say by whom?___
   Someone known to you or a stranger?_____

   Details_____

3. **Do you have a history of unwanted sexual contact by another person?** (e.g. unwanted kissing, hugging, touching, nudity, attempted intercourse? ☐ **Yes** ☐ **No**

   If yes, in the past?___ Is it still going on?___ Are you able to say by whom?___

   Someone known to you or a stranger?___

   Details:_____

4. **Have you ever been raped, or had sex against your will?** ☐ **Yes** ☐ **No**

   If yes, when?___ Are you able to say by whom?___ Someone known to you or a stranger?_____

   Details:_____

5. **Have you lived through a disaster** (like a flood, tornado, or plane crash)? ☐ **Yes** ☐ **No**

   If yes, please give age and circumstances:_____

   _____

6. **Are you a combat veteran, lived through war as a civilian in another country, or experienced an act of terrorism?** ☐ **Yes** ☐ **No**

   If yes, please describe_____

TRAUMA ASSESSMENT FORM
Form 3.1, Page 2/2

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7. **Have you been in a severe accident, or been close to death from any cause? ☐ Yes ☐ No**

   If yes, please describe_____

8. **Have you witnessed death or violence or the threat of death or violence to someone else? ☐Yes ☐ No**

   If yes, please describe_____

9. **Have you been the victim of a crime? ☐ Yes ☐ No**

   If yes, please describe_____

10. **Have you ever experienced seclusion or physical or chemical restraint in a hospital, institution, or other setting?☐ Yes ☐ No**

11. If yes, please describe_____

12. **When you were growing up, did anyone in your household use drugs or alcohol? Was any one in your house incarcerated? Did anyone in your house attempt suicide? Complete it? Have mental illness? Yes ☐ No**

13. **If yes to any of the above, have you experienced any emotional, psychological or physical problems** (e.g. flashbacks, nightmares, lost time, insomnia, numbness, confusion, memory loss, self injury, extreme fearfulness or terror, etc.), which may be related to the events? **☐ Yes ☐ No**

14. **Is this happening currently? ☐ Yes ☐ No**

    Please describe_____

15. **Were these questions upsetting to you? ☐ Yes ☐ No**

16. **Would you like to talk about this more, today? ☐ Yes ☐ No**

17. **If you find yourself thinking more about these issues later, how will you let someone know? What are some things you could do if you find yourself thinking about these experiences or having upsetting symptoms or feelings?**

    (Suggestions of possible ways)_____

Trauma Recovery Empowerment Profile (Pilot only)
Form 3.2, Page 1/1

TREP Rating Sheet (Harris and Fallot)

Client Name: _____
Clinician: _____ Assessment Date: _____ Length of time clinician has worked with or known the client: _____ months
Assessment Period ***(Circle the correct assessment period.)***
1 = Baseline 2 = Three months 3 = Six months 4 = Nine Months 5 = Twelve Months 6 = At Termination

Circle the rating point which best describes the consumer's skill level in the last month for each of the 11 skills.

1. Self-Awareness

1	2	3	4	5

2. Self-Protection

1	2	3	4	5

3. Self-Soothing

1	2	3	4	5

4. Emotional Modulation

1	2	3	4	5

5. Relational Mutuality

1	2	3	4	5

6. Accurate Labeling of Self and Others

1	2	3	4	5

7. Sense of Agency and Initiative Taking

1	2	3	4	5

8. Consistent Problem Solving

1	2	3	4	5

9. Reliable Parenting

1	2	3	4	5

10. Possessing a Sense of Purpose and Meaning

1	2	3	4	5

11. Decision Making and Judgment

1	2	3	4	5

Harris M. and Fallot R. 2004

Repeat DV Screening and Assessment
Form 2.5, Page 1/1

General Safety

I haven't asked about this for a while, but I wanted to check to see if all your relationships still feel safe to you or if you are being hurt or threatened in any way.

- ❑ Since we talked last, has anything changed in your life that has made you feel unsafe? Yes___ No___
- ❑ Have you had any experiences that made you afraid? Yes___ No___
- ❑ Is there anyone in your life who is making you feel afraid? Yes___ No___
- ❑ If yes, who did or is doing this?_____
- ❑ When has this happened?_____ Where_____ Is it still going on? Yes___No___

Domestic Violence

We haven't talked about your relationship with (partner) for a while.

- ❑ How are things going? Do you still feel safe with (partner)? Yes___No___
- ❑ How is he/she treating you?

_____

_____

Physical abuse

- ❑ **Since we talked about this last has he/she ever threatened you or physically hurt you?** Yes___ No___
  - ➢ In what ways? _____
  - ➢ When has this happened? _____Where_____ Is it still going on? Yes___ No___

Psychological abuse

- ❑ **Does he/she ever try to control what you do or try to undermine you in other ways by what he/she says or does?** Yes___No___
  - ➢ In what ways? _____
  - ➢ When has this happened? _____ Where_____ Is it still going on? Yes___ No___

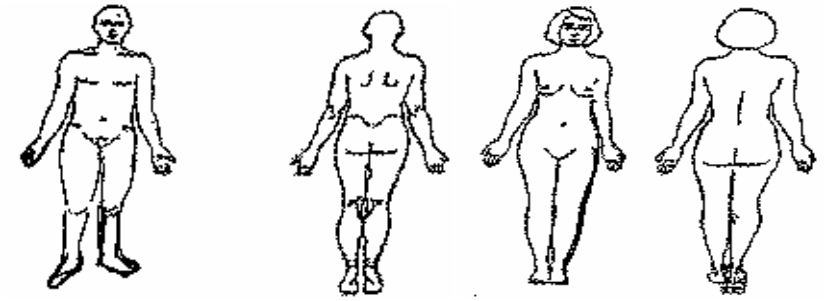
Sexual abuse

- ❑ **What about your sexual relationship? Does/he she ever try to use sexuality to harm or control you or force you to engage in sexual activities when you didn't want to?** Yes____ No___
  - ➢ In what ways? _____
  - ➢ When has this happened? _____ Where_____ Is it still going on? Yes___ No___

Other abuse

- ➢ **Since we talked about this last, has your partner done other things to harm or control you?** Yes___No___

Document description, size and location of injuries on body map: Mark Injuries using the scale below



1 = Threats of abuse or use of weapon
2 = Slapping, pushing, no injuries or lasting pain
3 = Punching, kicking, bruises, cuts and/or continuing pain
4 = Beating up, severe contusions, burns, broken bones
5 = Head injury, internal injury, permanent injury

Repeat DV Danger Assessment Questions Form 2.6

Framing Statements

- ❑ We have discussed your level of safety in the past, and I'd like to go over it again in case your level danger has increased.
- ❑ I'd like to check in with you at each visit about any changes in your level of safety and see if we need to think about other ways to help you be safe

Short Screen

- ❑ Are you afraid to go home? Yes___ No___
- ❑ Has anything changed in your relationship since we last met?
- ❑ Do you feel your level of danger has increased? Yes___ No___
- ❑ Has your partner done anything to make you more afraid? Yes___ No___
- ❑ Has your partner physically hurt you or threatened you recently? Yes___ No___
- ❑ What about sexually? Has your partner pressured you or forced you to have sex when you didn't want to? Yes___ No___
- ❑ What do you feel would be the safest thing to do? What would you like to do?

Full Danger Assessment

Since we last talked,

- ❑ Are the threats or physical violence becoming more frequent, severe or frightening? Yes___ No___
- ❑ Do you think your life may be in danger? Yes___ No___

- ❑ Has your partner become more controlling, making it harder for you to make phone calls or get away? Does he control most of your daily activities? Yes___ No___
  Has he/she been stalking you? Yes___ No___
  Has he threatened to kill you and/or do you think he is capable of killing you? Yes___ No___

- ❑ Does your partner have access to any weapons? Is there a gun in the house? Yes___ No___
  he/she used them against you or threatened you with them? Yes___ No___
- ❑ Are you planning to leave your partner? Yes___ No___
  Does your partner know about your plans? Yes___ No___
- ❑ Do violence and threats increase around impending separation Yes___ No___
- ❑ Has there been evidence of severe depression, alcohol or drug binges (uppers) or
- ❑ increasing mental instability (erratic changes in mood or behavior)? Yes___ No ___
  Has he/she threatened suicide or homicide? Yes___ No___

- ❑ Has he/she been violent outside the home? Yes___ No___
  Has your partner injured any animals or pets? Yes___ No___
  Has he been violent toward the children? Has this been recent? Yes___ No___

- ❑ Has your partner used his professional connections against you? Yes___ No___

- ❑ Has your partner engaged in any criminal activity? Yes___ No___
- ❑ Has your partner acted like he/she owns you. ("If I can't have you, no one will") Yes___ No___
  Is he/she violently jealous and always accusing you of infidelity? Yes___ No___

- ❑ Has he physically abused you while you were pregnant? Yes___ No___

- ❑ Has he/he tried to grab your neck or attempt to strangle you? Yes___ No___
  Injured you so badly you needed medical care? Yes___ No___

Advanced Directives for Mental Health Treatment

Form 5.1, Page 1/2

Personal Safety Form /Advanced Directive for De-Escalation in Time of Crisis

This form is a guide to gathering information with clients for the development of strategies to de-escalate agitation and distress so that restraint and seclusion can be averted. It should be used with all clients in conjunction with the Trauma Assessment Form. It is recommended for use in inpatient facilities, psychiatric emergency rooms, crisis stabilization and other diversion units but is helpful to discuss with clients when they are not in crisis (i.e. during outpatient treatment or in residential settings). The information obtained should be incorporated into the treatment plan for this client.

1. It is helpful for us to be aware of the things that can help you feel better when you're having a hard time. Have any of the following ever worked for you? These alternatives may not always be available but I'd like us to work together to figure out what would be most helpful to you if you are hospitalized at some point.

	Voluntary time out in your room		*Listening to music*
	Voluntary time out in quiet room		*Reading a newspaper/ book*
	Sitting by the nurses station		*Watching TV*
	Talking with another consumer		*Pacing the halls*
	Talking with staff *Talk with spiritual/faith leader*		*Calling a friend* *Meditate or pray*
	A warm drink		*Calling your therapist*
	Eating something		*Pounding some clay*
	Punching a pillow		*Exercise*
	Writing a diary/ journal		*Using ice on your body*
	Deep breathing exercises		*Putting hands under cold water*
	Going for a walk with staff		*Lying down with cold face cloth*
	Taking a hot shower		*PRN medication*
	Wrapping up in a blanket		*Other*

2. Is there a person who has been helpful to you when you're upset? **(Y/N)** Would you like them to come and visit you? **(Y/N)** Can we assist in this process? **(Y/N)** If you are in a position where you are not able to give us information to further your treatment, do we have your permission to call and speak to:

_____(**Name**)_____(**Phone**)

Are there any particular people that are unhelpful or abusive to you when you are upset that you would not want contacted if you require hospitalization? _____(**Name, Relationship)**

If you agree that we can call to get information, sign below:

Client signature_____Witness_____Date:_____

Advanced Directives for Mental Health Treatment
Form 5.1, Page 2/2

3. What are some of the things that make it more difficult for you when you're already upset? Are there particular "triggers" that you know will cause you to feel or act more upset?

	Being touched		*Being isolated*
	Bedroom door open		*People in uniform*
	Particular time of day (when?)		*Time of the year (when?)*
	Loud noise		*Yelling*
	Not having control/ input (explain)		*Other (please list)*

4. Have you ever been restrained in a hospital or other setting, for example, in a crisis stabilization unit or at home?

	Physically/ Mechanically	**Chemically**
When?		
Where?		
What happened?		

5. If you are escalating or in danger of hurting yourself or someone else, there may be a need to use a physical, or mechanical restraint (for example in an ER, hospital setting or ambulance). All of these alternatives may not be available, but if it becomes necessary, we'd like to know your preferences.

Time out in your room		
Quiet room (unlocked)		*Seclusion (locked door)***
Physical hold	*Safety coat*	*Other*
*3-point restraint**	*Face up?*	*Face down?*
*4-point restraint with legs together**	*Face up?*	*Face down?*

* These restraints are not allowed for people with mental retardation
** Locked door seclusion is not allowed for people with mental retardation

6. Do you have a preference regarding the gender of staff assigned to you during and immediately after a restraint?
   Women Staff___ Male Staff___ No Preference___

7. Is there anything that would be helpful to you during a restraint? Please describe.
   _____

8. If you are hospitalized, staff may be required to administer medication along with physical restraints. In this case, what medications have been especially helpful or harmful to you? Please describe.
   Helpful:_____
   Harmful:_____

9. Many facilities do room checks here to make sure you are okay at night. Is there anything that would make room checks more comfortable for you?
   _____

Please incorporate the information obtained in the Personal Safety Form into the treatment plan for this client

Advanced Directives for Mental Health Treatment
Form 5.2

(Please refer to the Psychiatric Advance Directives Toolkit for instructions to complete this worksheet.)

1. Symptom(s) I might experience during a period of crisis:

_____

_____

_____

_____

_____

2. Medication instructions.

A. I agree to administration of the following medication(s):

_____

_____

_____

_____

_____

B. I do not agree to administration of the following medication(s):

_____

_____

_____

_____

_____

C. Other information about medications (allergies, side effects)

_____

_____

_____

_____

_____

3. Facility Preferences.

A. I agree to admission to the following hospital(s):

_____
_____
_____
_____

B. I do not agree to admission to the following hospital(s):

_____
_____
_____
_____

C. Other information about hospitalization:

_____
_____
_____
_____

4. Emergency Contacts in case of mental health crisis:

Name:_____

Address:_____

Home Phone # _____

Work Phone #_____

Relationship to Me: _____

Name:_____

Home Phone # _____

Work Phone #_____

Relationship to Me: _____

Psychiatrist:_____

Work Phone #_____

Case Manager/Therapist: _____

Work Phone #_____

5. Crisis Precipitants. The following may cause me to experience a mental health crisis:

_____

_____

_____

_____

_____

6. Protective Factors. The following may help me avoid a mental health crisis:

_____

_____

_____

_____

_____

7. Response to Hospital. I usually respond to the hospital as follows:

_____

_____

8. Preferences for Staff Interactions.

A. Staff of the hospital or crisis unit can help me by doing the following:

B. Staff can minimize use of restraint and seclusion by doing the following:

9. I give permission for the following people to visit me in the hospital:

10. The following are my preferences about ECT:

_____

_____

_____

_____

11. Other Instructions.

A. If I am hospitalized, I want the following to be taken care of at my home:

_____

_____

_____

_____

_____

_____

B. I understand that the information in this document may be shared by my mental health treatment provider and with any other mental health treatment provider who may serve me when necessary to provide treatment in accordance with this advance instruction. Other instructions about sharing of information are as follows:

_____

_____

_____

_____

---

12. Legal documentation for Advance Directives:

A. Signature of Principal

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full impact of having made this advance instruction for mental health treatment.

Signature of Principal Date

Nature of Witnesses
I hereby state that the principal is personally known to me, that the principal signed or acknowledged the principal's signature on this advance instruction for mental health treatment in my presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that I am not:

- ❑ The attending physician or mental health service provider or an employee of the physician or mental health treatment provider;
- ❑ An owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident; or
- ❑ Related within the third degree to the principal or to the principal's spouse.

B. Affirmation of Witnesses

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this advance instruction for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is: A person appointed as an attorney-in-fact by this document; The principal's attending physician or mental health service provider or a relative of the physician or provider; The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or A person related to the principal by blood, marriage, or adoption.

Witnessed by:

Witness:_____ Date: _____

Witness:_____ Date: _____

State of Illinois, County of Cook

C. Certification of Notary Public

State of Illinois, County of Cook

I, _____ , a Notary Public for the County cited above in the State of Illinois, hereby certify that _____ appeared before me and swore or affirmed to me and to the witnesses in my presence that this instrument is an advance instruction for mental health treatment, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that _____ and _____ witnesses, appeared before me and swore or affirmed that they witnessed _____ sign the attached advance instruction for mental health treatment, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing they were not (i) the attending physician or mental health treatment provider or an employee of the physician or mental health treatment provider and (ii) they were not an owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident, and (iii) they were not related within the third degree to the principal or to the principal's spouse. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This is the _____ day of _____, 20___.

Notary Public

My Commission expires:

D. Statutory Notices

Notice to Person Making an Instruction For Mental Health Treatment. This is an important legal document. It creates an instruction for mental health treatment. Before signing this document you should know these important facts: This document allows you to make decisions in advance about certain types of mental health treatment. The instructions you include in this declaration will be followed if a physician or eligible psychologist determines that you are incapable of making and communicating treatment decisions. Otherwise you will be considered capable to give or withhold consent for the treatments. Your instructions may be overridden if you are being held in accordance with civil commitment law. Under the Health Care Power of Attorney you may also appoint a person as your health care agent to make treatment decisions for you if you become incapable. You have the right to revoke this document at any time you have not been determined to be incapable. YOU MAY NOT REVOKE THIS ADVANCE INSTRUCTION WHEN YOU ARE FOUND INCAPABLE BY A PHYSICIAN OR OTHER AUTHORIZED MENTAL HEALTH TREATMENT PROVIDER. A revocation is effective when it is communicated to your attending physician or other provider. The physician or other provider shall note the revocation in your medical record. To be valid, this advance instruction must be signed by two qualified witnesses, personally known to you, who are present when you sign or acknowledge your signature. It must also be acknowledged before a notary public.

Notice to Physician or Other Mental Health Treatment Provider. Under North Carolina law, a person may use this advance instruction to provide consent for future mental health treatment if the person later becomes incapable of making those decisions. Under the Health Care Power of Attorney the person may also appoint a health care agent to make mental health treatment decisions for the person when incapable. A person is "incapable" when in the opinion of a physician or eligible psychologist the person currently lacks sufficient understanding or capacity to make and communicate mental health treatment decisions. This document becomes effective upon its proper execution and remains valid unless revoked. Upon being presented with this advance instruction, the physician or other provider must make it a part of the person's medical record. The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the advance instruction when the person is determined to be incapable, unless compliance is not consistent with G.S. 122C-74(g). The physician or other mental health treatment provider shall promptly notify the principal and, if applicable, the health care agent, and document noncompliance with any part of an advance instruction in the principal's medical record. The physician or other mental health treatment provider may rely upon the authority of a signed, witnessed, dated, and notarized advance instruction, as provided in **755 ILCS 43 Mental Health Treatment Preference Declaration Act.**