**Using this Word Template**

This document has been created to allow users to enter information electronically into the Niagara Safety / Crisis Guideline package. The package includes:

1. **Fax Cover Sheet:** The name & fax number for COAST Niagara and Niagara Health System PERT have already been entered. The package should also be faxed to other organizations who may be involved in reacting to safety / crisis concerns. Please enter the contact person, name of the organization, and their fax number in this sheet. No part of the Safety / Crisis Plan should appear on the cover sheet.

Please remember to follow all legislation regarding sharing and securing personal and confidential information, including ensuring that the receiving fax machine is in a secure area.

1. **Safety / Crisis Plan Template:** Please ensure that the first page of the Safety / Crisis Plan starts on its own page and the last page ends on its own page. Use the ‘enter’ key on your keyboard in any blank space to ‘push’ the Consent to Share document to its own page.

Please remember that COAST and PERT pay particular attention to the information provided under “List stressors and triggers:” and “What would you NOT find helpful during a crisis?” when responding.

1. **Consent to share information:** COAST Niagara and Niagara Health System, PERT have already been entered on this form. Other organizations and informal supports who may be involved in reacting to safety / crisis concerns should also be entered. Consents require that the organization be listed, not the name of the program or the staff member. The individual / Guardian / Substitute Decision Maker need to initial the right box beside the organizations name AND sign the bottom of the form.

If the individual /Guardian / Substitute Decision Maker withdraws the consent for one or more organizations, all organizations must be informed and provided with an updated consent.

Please contact Tom Archer at [tarcher@bethesdaservices.com](mailto:tarcher@bethesdaservices.com) if you require assistance with this package.

**FAX**

**Niagara Safety / Crisis Plan Sharing**

Copies of Individual Safety / Crisis Plans should be shared with the individual and, with the individual’s consent, organizations and individuals who were involved in its development and identified as playing a role in supporting the individual during crisis. Copies should also be shared with COAST Niagara and Niagara Health System PERT so that they can be easily accessed and important information utilized should they respond to the crisis. COAST and PERT will send confirmations of receipt to sender.

**Date:**

**Sent From:**

Name:       Organization:

Phone:       Fax:

**Sent To:**

|  |  |
| --- | --- |
| **Organization / Name** | **FAX #** |
| Crisis Outreach and Support Team (COAST) Niagara | 905-641-5297 |
| Niagara Health System, Psychiatric Emergency Response Team (PERT) | 905-704-4755 |
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**Individual Safety / Crisis Plan**

**Niagara Community Crisis Guideline**

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| --- | --- |
| **Date:** | **DOB:** |
| **Name:** | **Emergency Contact/Substitute Decision Maker/Guardian: (name and number below)** |
| **Address:** | **Contact #:** |
| **Client Tel #:** |
| **Psychiatrist:** | **Contact #:** |
| **Family Physician:** | **Contact #:** |
| **Lead case manager / Integrated Community Lead:** | **Contact #:** |
| **Known Diagnoses (medical and psychiatric):** | **Contact to collect Medication History:**    **Contact #:**  **\*Be sure to bring current list of medication to hospital** |

**List Stressors or Triggers:**

**What would you NOT find helpful during a crisis?**

**LEVEL 1 (BEGINNING ESCALATION PHASE or STRESS PHASE/Early Warning Signs)**

|  |  |
| --- | --- |
| **What do you feel when you are stressed?** | **What helps at this time?** |
|  |  |

**LEVEL 2 (PRE-CRISIS or DISTRESS PHASE)**

|  |  |
| --- | --- |
| **When you are feeling overwhelmed what might we see?(emotional/physical)** | **What helps at this time?** |
|  |  |

**LEVEL 3 Crisis Phase**

|  |  |
| --- | --- |
| **How do you know when you are in crisis and need help? What do you feel and do?** | **What helps at this time?** |
|  |  |

**Who should we notify when you are in crisis?**

**Summary of Plan of Care:**

|  |  |
| --- | --- |
| **Agency Involved** | **Service Provided** |
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| **I agree with this safety / crisis plan:**  **(Signature of the individual / Guardian / Substitute Decision Maker)** | **Valid until:** |
| **Client/Guardian/Substitute Decision Maker:**  **(Please print name)** | **Date:** |
| **Witness:**  **(Please print name and sign)** | **Date:** |

**Date of next review:**

**MENTAL HEALTH CONSENT FOR THE COLLECTION, USE AND**

**DISCLOSURE OF PERSONAL HEALTH INFORMATION**

**1. I have had all my questions answered to my satisfaction and fully understand that specific providers will either collect, use and/or disclose my personal health information.**

**2. I have been advised and I am aware that the following providers will collect, use and/or disclose my personal health information.**

**3. I have initialed the specific boxes to indicate my consent with respect to the collection, use and/or disclosure of my personal health information.**

|  |  |
| --- | --- |
| **Organization Name** | **Initial** |
| **Crisis Outreach and Support Team (COAST) Niagara** |  |
| **Niagara Health System** |  |
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I have been advised and I understand that I can withdraw my consent to the collection, use and/or disclosure of my personal health information at any time by contacting the Organizations listed on this consent**.**

**THEREFORE, HAVING REVIEWED AND FULLY UNDERSTANDING THE PURPOSE OF THIS CONSENT,** I consent to the collection, useand disclosure of my personal health information to the specific providers indicated above.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Print Individual Name Individual Signature

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Print Guardian / Substitute Decision Maker name, if applicable Guardian / Substitute Decision Maker Signature

Date (dd/mm/yyyy)