BURRELL BEHAVIORAL HEALTH

Supportive Care Pathway Crisis Follow-Up

Please send this completed form to **Crisis Team SW** email group**(SW and CR Only)** and **CMHS Risk Notification email** **(KC only)**
BEFORE NOON on the day before the weekend or long holiday.

Client Details

Date *(mm/dd/yyyy)*	**MRN**	**Client Legal Name**	**Name Client Would Like Used**

Current Risk Level	**Date of Last Contact** *(mm/dd/yyyy)*	**Date of Last Columbia**
☐ High ☐ Moderate ☐ Low		

Was the Safety Plan Reviewed?	**Has Client Been Given Handout?**	**Check Here if Client Has No Phone**
☐ Yes ☐ No	☐ Yes ☐ No	☐ This client does not have a phone

Contact Intervals Chosen by Client *(in days)*
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14

Contact Information

Specific Date and Time of Follow-Up Needed:

Is Client Aware of This Follow-Up?	**Follow-Up Date** *(mm/dd/yyyy)*	**Follow-Up Time**
☐ Yes ☐ No		

Client Address - Street	**Client Phone Number** *(including area code)*	
City	**State**	**Zip Code** *(5 digit)*

Emergency Contact Name	**Emergency Contact Phone Number**	**Has Provider Confirmed This?**
		☐ Yes ☐ No

Provider Information

Treatment Provider Completing Form	**Provider Phone Number**	**Provider Email**

Notes