Member Basic Information Fact Sheet

*One Sheet for Every Member in the Household***Keep Accessible for Caregivers*

Names of Members in Household	Social Security Number	Date of Birth	Age

Address:

Phone Number(s):

In Case of Emergency Call

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

Emergency Mobile Crisis Phone#:
Police Department Phone#:
Fire Department Phone#:
Rescue Ambulance Phone#:
Poison Control Phone#:
Physician's Name & Phone #:
Physician's Name & Phone #:
Therapist's Name & Phone #:
Health Insurance/Medicaid Information:
Behavioral Health Diagnosis:
Medical Diagnosis:
Allergies:
Medications:

Special Instructions:

Connecticut BHP
Supporting Health and Recovery

Wellness and Recovery Crisis Plan:

Crisis Plan			
Provider Name:			
Member ID#:			
Member's Current Phone #:			
Plan Developed By (Include all parties involved in developing crisis/safety plan and contact information):			
Select all applicable options:			
	Case Manager		LHMA's
	CMP		MCO
	Current Inpatient Treater		Member
	Current Outpatient Treater		Mobile Crisis Team
	DDS		Partnership/Peer Support
	ED		PRTF
	EMPS		RTC
	Family		School
	Group Home		State Agency
	ICM/CCM		Other
Additional Information: Include formal and informal supports, include contact names/phone #:			
Specify current living arrangement (Document support network, including names, addresses and phone numbers):			
	Family Home		Safe Home
	Foster Family Home		Shelter
	Group Home		Sober Housing
	Homeless		STAR
	Independent Living		Supervised Housing
	RTC		Supportive Housing
			Other
Additional Information:			
Current Strengths and Functioning (Describe key strengths and needs related to behavioral health, vocational, school, social relationships, daily living skills, natural supports):			

Signs and symptoms of de-compensation:

Safety Concerns: (Any information either about the member, family or living situation, which should be known when member is in crisis.):

Select all applicable options

	Access to Weapons		History of Arrests
	Current Charges Pending		History of Police Interventions
	Current Parole		History of Suicide Attempt(s)
	History/Current JJ Involvement		Substance use
	History of Homicide Attempt(s)		Volatile Home Environment
			Other

Please Specify:

Substance use (Past or present substance use issues):

	Current Alcohol		Past Alcohol
	Current Marijuana		Past Marijuana
	Current Other Illicit		Past Other Illicit
	Current Prescription Drugs		Past Prescription Drugs
	Family Members with Substance Abuse		Other

Please Specify:

Medical/Special Needs (Any health issue or special needs which should be taken into consideration when intervening with the client. Include medical diagnosis that impact behavioral health/access to treatment/services.)

Select all applicable options:

	Asthma		Eating Disorder
	Autism/PDD Spectrum		Hepatitis
	Brain Injury		Hypertension
	Cirrhosis		Obesity
	Chronic Obstructive Pulmonary Disease COPD		Physical Disabilities
	Congestive Heart Failure (CHF)		Post Partum Depression
	Coronary Artery Disease (CAD)		Pregnancy/High Risk Pregnancy
	Diabetes		Seizure Disorder
			Other

Please Specify:

Triggers/Risk Factors ("Red Flags"/Stressors that may trigger a crisis):			
Select all applicable options:			
	Change in Schedule		Police/Legal Involvement
	Change in Treatment Providers		Recent Loss/Trauma
	Criticizing/Scolding		Rejection
	Family Interaction		School/Work Difficulty
	Over-stimulating Environment		Substance use
	Peer Conflict		Other
Additional Information:			

Reactive Crisis Planning (Interventions/steps successfully utilized in the past to resolve crisis; using members strengths and support systems)
Additional Information (list specific steps/interventions successful in the past):
Proactive Crisis Plan of Action (Steps/Interventions to prevent Crisis; inclusive of members strengths and natural supports to avert crisis):
Please specify specific steps to take to prevent crisis (i.e. call EMPS, Mobile Crisis, 211, contact current provider, provider timeout, etc.):
Is this Wellness recovery Crisis Plan form used by provider and/or member:

Provider Name (print) and Signature:	Date:
Member Name (print) and Signature:	Date:

Current Medical Contact Information

Member Name: _____

Current Diagnosis(es) if known Date: _____

_____

_____

_____

Current Goals and Priorities Date: _____

_____

_____

_____

Primary Physician's Office: Contact Information

Address: _____ Phone: _____

PCP Name: _____ Nurse's Name: _____

Specialist Provider's Office: Contact Information

Address: _____ Phone: _____

Name: _____ Specialty _____

Address: _____ Phone: _____

Name: _____ Specialty _____

Address: _____ Phone: _____

Name: _____ Specialty _____

Others (Recreational, Educational, Employment, Mentoring, DCF, DSS, etc.)

Address: _____ Phone: _____

Name: _____ Specialty _____

Address: _____ Phone: _____

Name: _____ Specialty _____

Address: _____ Phone: _____

Name: _____ Specialty _____

Allergies

Allergy to: _____ Reaction: _____
Allergy to: _____ Reaction: _____
Allergy to: _____ Reaction: _____
Allergy to: _____ Reaction: _____

Medication Records

Current

Medication Name	Date Started	Dosage	How Often	Purpose	Any Side Effects

History

Medication Name	Date Started	Dosage	How Often	Purpose	Any Side Effects

Pharmacy Contact Information:

Name:: _____ Phone _____
Address: _____ Town/City _____