

Provider Worksheet

Survivor Current Needs

Date: _____ Provider: _____

Survivor Name: _____ Location: _____

This session was conducted with (check all that apply):

Child Adolescent Adult Family Group

Provider: Use this form to document what the survivor needs most at this time. This form can be used to communicate with referral agencies to help promote continuity of care.

1. Check the boxes corresponding to difficulties the survivor is experiencing.

Behavioral	Emotional	Physical	Cognitive
<input type="checkbox"/> Disorientation	<input type="checkbox"/> Acute stress reactions	<input type="checkbox"/> Headaches	<input type="checkbox"/> Inability to accept/cope with death of loved one(s)
<input type="checkbox"/> Increased drug, alcohol, or prescription drug use	<input type="checkbox"/> Acute grief reactions	<input type="checkbox"/> Stomachaches	<input type="checkbox"/> Distressing dreams or nightmares
<input type="checkbox"/> Isolation/withdrawal	<input type="checkbox"/> Sadness, tearfulness	<input type="checkbox"/> Sleep difficulties	<input type="checkbox"/> Intrusive thoughts or images
<input type="checkbox"/> High-risk behavior	<input type="checkbox"/> Irritability, anger	<input type="checkbox"/> Difficulty eating	<input type="checkbox"/> Difficulty concentrating
<input type="checkbox"/> Regressive behavior	<input type="checkbox"/> Anxiety, fear	<input type="checkbox"/> Worsening of health conditions	<input type="checkbox"/> Difficulty remembering
<input type="checkbox"/> Separation anxiety	<input type="checkbox"/> Despair, hopelessness	<input type="checkbox"/> Fatigue/exhaustion	<input type="checkbox"/> Difficulty making decisions
<input type="checkbox"/> Violent behavior	<input type="checkbox"/> Guilt or shame	<input type="checkbox"/> Chronic agitation	<input type="checkbox"/> Preoccupation with death/destruction
<input type="checkbox"/> Maladaptive coping	<input type="checkbox"/> Feeling emotionally numb, disconnected	<input type="checkbox"/> Other _____	<input type="checkbox"/> Difficulties completing assignments or chores
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____

2. Check the boxes corresponding to other specific concerns.

- | | |
|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Past or preexisting trauma/psychological problems/substance abuse problems | <input type="checkbox"/> Living arrangements |
| <input type="checkbox"/> Injured as a result of the emergency | <input type="checkbox"/> Lost job or school |
| <input type="checkbox"/> At risk of losing life during the emergency | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Loved one(s) missing or dead | <input type="checkbox"/> Physical/emotional disability |
| <input type="checkbox"/> Displaced from home | <input type="checkbox"/> Medication stabilization |
| <input type="checkbox"/> Assisted with rescue/recovery | <input type="checkbox"/> Concerns about child/adolescent (for parent) |
| <input type="checkbox"/> Pets missing/injured/dead | <input type="checkbox"/> Separation from primary caregiver (for child) |
| <input type="checkbox"/> Other _____ | |

3. Please make note of any other information that might be helpful in making a referral.

4. Referral

- Within school (specify) _____
- Community response agencies
- Professional mental health services
- Other _____
- Substance abuse treatment
- Other community services
- Medical treatment

5. Was the referral accepted by the individual? Yes No

