STATE OF ALASKA
DEPARTMENT OF HEALTH
DIVISION OF BEHAVIORAL HEALTH
1115 CRISIS SERVICE CONTACT FORM

☐ **Peer Based Crisis Service**

☐ **23 Hour Crisis Stabilization and Observation**

☐ **MOCR**

1115 Crisis Service Contact

Contact Date: _____ Case/Record Number: _____

Patient Name: : _____ DOB: : _____ Medicaid ID: : _____

Address: : _____ Insurance ID: : _____

Start Time: : _____ Stop Time: : _____ Duration: : _____

Service Provider: : _____

Location: : _____

☐ By Appointment ☐ Community Service Patrol ☐ Drop-in / Office ☐ Emergency Outreach intervention
☐ Hospital / On-call intervention ☐ Phone ☐ In Home ☐ In Community ☐ MOCR 48 Crisis Services Follow Up
If Other, Specify: : _____

Symptoms Related to Complaint:

☐ Anxiety
☐ Depression
☐ Suicidal
☐ Homicidal
☐ Substance use related
☐ Unknown
If Other, Specify:
: _____

Psychosocial/Environmental Features:

☐ Problems with primary support groups
☐ Problems related to the social environment
☐ Educational problems
☐ Occupational problems
☐ Housing problems
☐ Economic problems
☐ Problems with access to health care services
☐ Problems related to interaction with the legal system/crime
☐ Other Psychosocial and Environmental problems
If Other, Specify: : _____

Presenting Risk (Presenting risk is determined from an evidence-based risk assessment tool.):

☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all ☐ Not present ☐ Unknown

Presenting Problem (Nature of crisis, summary of risk assessment):

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Assessment (Recipient's mental, emotional & behavioral status/functioning in relation to crisis. Include multiaxial diagnosis/mental status exam (if appropriate):
Services (Describe services and interventions provided by the clinician and/or Behavioral Health Clinic Associate):
Follow-Up Disposition:

Mental Health Professional Clinician (if applicable): _____ _____
Signature and Credentials Date

Rendering Provider: _____ _____
Signature and Credentials Date