

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"/> Extreme disorientation <input type="checkbox"/> Excessive drug, alcohol, or prescription drug use <input type="checkbox"/> Isolation/withdrawal <input type="checkbox"/> High risk behavior <input type="checkbox"/> Regressive behavior <input type="checkbox"/> Separation anxiety <input type="checkbox"/> Violent behavior <input type="checkbox"/> Maladaptive coping <input type="checkbox"/> Other _____	<input type="checkbox"/> Acute stress reactions <input type="checkbox"/> Acute grief reactions <input type="checkbox"/> Sadness, tearful <input type="checkbox"/> Irritability, anger <input type="checkbox"/> Feeling anxious, fearful <input type="checkbox"/> Despair, hopeless <input type="checkbox"/> Feelings of guilt or shame <input type="checkbox"/> Feeling emotionally numb, disconnected <input type="checkbox"/> Other _____	<input type="checkbox"/> Headaches <input type="checkbox"/> Stomachaches <input type="checkbox"/> Sleep difficulties <input type="checkbox"/> Difficulty eating <input type="checkbox"/> Worsening of health conditions <input type="checkbox"/> Fatigue/exhaustion <input type="checkbox"/> Chronic agitation <input type="checkbox"/> Other _____	<input type="checkbox"/> Inability to accept/cope with death of loved one(s) <input type="checkbox"/> Distressing dreams or nightmares <input type="checkbox"/> Intrusive thoughts or images <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Difficulty remembering <input type="checkbox"/> Difficulty making decisions <input type="checkbox"/> Preoccupation with death/destruction <input type="checkbox"/> Other _____

2. Check the boxes corresponding to any other specific concerns

- Past or preexisting trauma/psychological problems/substance abuse problems
- Injured as a result of the disaster
- At risk of losing life during the disaster
- Loved one(s) missing or dead
- Financial concerns
- Displaced from home
- Living arrangements
- Lost job or school
- Assisted with rescue/recovery
- Has physical/emotional disability
- Medication stabilization
- Concerns about child/adolescent
- Spiritual concerns
- Other: _____

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

4. Referral

- | | |
|--|--|
| <input type="checkbox"/> Within project (specify) _____ | <input type="checkbox"/> Substance abuse treatment |
| <input type="checkbox"/> Other disaster agencies | <input type="checkbox"/> Other community services |
| <input type="checkbox"/> Professional mental health services | <input type="checkbox"/> Clergy |
| <input type="checkbox"/> Medical treatment | <input type="checkbox"/> Other: _____ |

5. Was the referral accepted by the individual?

- Yes No