

MY CRISIS COMPASS



Youth's First & Last Name:		Nickname (if applicable):	
Date of Birth:		Sex and Preferred Pronouns:	
Safety plan? Yes No		(If you don't have a safety plan, we recommend creating one with your clinician and attaching it, along with any other relevant documents.)	
Safety Concerns:			
Known Triggers:			
Known Comforts:			
Relevant Behavioral/ Developmental/ Medical Needs:			
Caregiver Support Needs:			

MY CRISIS COMPASS

acmh-mi.org | HELP@ACMH-MI.ORG | (888) ACMH-KID

Primary Caregiver Name and Relation:	Back-up Person(s) Name and Relation:
Phone Number(s):	Phone Number(s):
Address:	Address:
Email(s):	Email(s):

Mental Health Provider Name:	Insurance Provider:	Phone:
Phone Number(s):	Subscriber Name:	
Address:	Policy/Group Number:	
Email(s):	Subscriber ID/Member ID:	

Current Medication	Dose	Frequency	Duration

Previous Crisis Interventions and Additional Information:

Completed By:

Date:

