PATIENT SAFETY PLAN

INFORMATION

PATIENT NAME: _____ DATE & TIME OF INITIATION _____

WAS FAMILY, FRIENDS, OR CAREGIVERS OF THE PATIENT INVITED TO PARTICIPATE? YES NO* IF NO - WHY NOT?

LIST THE NAMES OF THOSE INVOLVED:

NAME	RELATIONSHIP

UNDERSTANDING YOUR FEELINGS AND BEING AWARE OF EARLY WARNING SIGNS WILL MAKE IT EASIER FOR YOU TO TAKE CARE OF YOURSELF AND NOT BECOME OVERWHELMED TO THE POINT OF WANTING TO HARM YOURSELF.

WARNING SIGNS

WHAT STARTS OR TRIGGERS SUICIDAL/HOMICIDAL THOUGHTS?
(examples: events, people, loss, holidays, arguments, pain)

WHAT **ARE SOME EARLY WARNING SIGNS? / WHAT DO YOU FEEL?**
(examples: withdrawal, substance use, impulsivity, anger)

INTERNAL COPING STRATEGIES

INSTEAD OF HARMING MYSELF/OTHERS, HERE ARE THINGS I CAN DO:
(call a friend, call a hotline, see my therapist, go for a walk, attend a support group, stick to my treatment plan)

THESE ARE THE REASONS I MAY NOT BE ABLE TO DO THESE THINGS:

_____ **I understand that driving may be dangerous if I am not fully alert and oriented and I will not drive if I feel impaired.**

_____ **I understand that managing my medications may be difficult if I am distracted, angry, or confused and I will ask for help with managing my medications if needed.**

WHO? _____
(NAME & PHONE NUMBER)

_____ **I understand that the first few days after discharge it is important that I am not alone and I will call one of the numbers below if I am feeling lonely, unsafe, or need someone to talk to.**

_____ **I understand that I should not use drugs, alcohol, medications not currently prescribed to me, or get pregnant while taking psychotropic medications and that all medications need to be safely stored or disposed of.**

CONTACTS WHO CAN HELP

THESE ARE IMPORTANT NUMBERS FOR ME TO ALWAYS HAVE AVAILABLE AND USE WHEN I NEED TO. I WILL CALL ONE OR MORE OF THESE WHEN I START TO FEEL LIKE HURTING MYSELF.

FRIEND: _____ _____
FRIEND: _____ _____
THERAPIST: _____ _____

OTHER: _____ _____
JOURNEYS IN MHW **919-374-7283**
SUICIDE HOTLINE **1-800-273-8255**

GREETING A SAFE ENVIRONMENT

FIREARMS SAFETY PLAN - If you have access to firearms, we ask that you take some time to make a plan for safety below.

I have firearms in my home. NO YES* IF YES, COMPLETE BELOW
What type of firearm(s)? _____
Where is it (they) stored _____
I have access to firearms NO YES* IF YES, COMPLETE BELOW
Where? _____ Who? _____

Who will dispose of or safely store your firearms before you are discharged?
Name & Phone _____
Name & Phone _____

_____ **Initial** **Having firearms, or access to them, increases the chances of harming myself. I understand that they need to be safely disposed of or stored by someone else.**

My signature below authorizes the staff to contact the above people to verify implementation of this plan, if necessary.

SIGNATURE OF PATIENT: **DATE/TIME** **SIGNATURE OF THERAPIST:** **DATE/TIME**