**Safety Plan**

**Name:**       **Date of Birth:**

**MIS #:**

1. My current stressors and recent loss/other events or warning signs that a mental health crisis is imminent:
	1.
	2.
	3.
2. My internal coping skills:
	1.
	2.
	3.
3. My positive distractions:
	1.
	2.
	3.
4. My support people::
	1. Primary:
	2. Secondary:
	3. Other:
5. My professional helpers:
	1. Treatment team providers:
	2. VCSB ES:
	3. 911
6. My life is valuable because:
	1.
	2.
	3.
7. I will make my environment safe by:
	1.
	2.
	3.
8. My follow-up plan:
	1. (Client Contribution)
	2. (Clinician Contribution)
	3. (Other family/friend/provider)
9. My Future appointments:
	1.
	2.
	3.

Client Signature Date

Guardian or Authorized Representative Signature Date

Guardian or Authorized Representative Name

[ ]  Refusal to sign\*

\*My signature above indicates that I understand my plan and that I commit to follow it as outlined above.

VCSB Staff Signature Date

Witness Consult Signature (If applicable) Date

Witness Consult Name (If applicable)