****FORM NOT TO BE RELEASED TO PATIENT UPON REQUEST OF MEDICAL RECORDS****

**Today's Date:** _____

## Arizona Crisis System Family/Support Collateral Form:

Historical Information Provided by Family Member or Other Interested Party

As providers of crisis mental health care, we value the input of family members and other support persons and recognize the importance of considering this information when making decisions about involuntary psychiatric treatment. We ask that you complete as much of this form as possible to aid us in our clinical decision making.

This form was inspired by a similar form created in Alameda County, which was adapted for use in the Arizona mental health crisis system jointly by Arizona crisis providers, community mental health advocates, and family members of people living with Severe Mental Illness in order to provide a means for family members and other interested parties to communicate the patient's mental health history.

**Note:** This form will become a part of the medical record, but as Protected Health Information (PHI) obtained from someone other than a health care provider under a promise of confidentiality, access to this form will be restricted, and **it will NOT be released to the patient** should they request to view their medical records (45 CFR 164.524 (a)(2)(v)).

| | |
|---|---|
| **Name of Patient:** | **Date of Birth:** _____ |
| **Address:** | **Phone:** _____ |
| **Primary Language:** | ☐ **Check if interpreter needed/preferred** |
| **Religion/Religious Accommodations:** | |

☐**Yes** ☐**No** Please ask the patient to sign an authorization permitting the mental health provider to communicate with me about his/her care.

☐**Yes** ☐**No** The patient has a Mental Health Care Power of Attorney or Psychiatric Advance Directive. (If yes, and a copy is available, attach a copy to this form.)

**Brief History of Mental Illness** *Attach additional pages, if necessary*

Does patient carry a psychiatric diagnosis? ☐ Yes ☐ No ☐ Don't Know

Please Explain:

Age Illness began:

Do you know of any substance use/abuse? ☐ Yes ☐ No ☐ Don't Know

Please Explain:

Prior petitions and/or instances of being placed on court-ordered treatment ☐ Yes ☐ No ☐ Don't Know If yes, when and what was the outcome?



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Prior psychiatric hospitalizations? ☐ Yes ☐ No ☐ Don't Know **Today's Date:** _____

If yes, how many, when, reason for admission and name of facility:

Does patient have a legal guardian? ☐ Yes ☐ No ☐ Don't Know
If yes, Name: Phone: _____
If yes, does the guardian have mental health authority? ☐ Yes ☐ No ☐ Don't Know
Does patient have a history of a developmental disability, special education, or IEP in school?
☐ Yes ☐ No ☐ Don't Know

If yes, Please Explain:

## Current Medications (*Psychiatric and Medical*)

Medications:

Medications patient has responded well to:
Medications patient has **NOT** responded well to:

### Treating Psychiatrist and Case Manager

Patient is designated SMI in the State of Arizona ☐ Yes ☐ No ☐ Don't Know
If yes, name of SMI Clinic:
Psychiatrist/Psych NP/PA: Phone: _____
Case Manager: Phone: _____

### Medical

Significant Medical Conditions:
Allergies to Medications, Food, Chemicals, Other:
Primary Care Physician: Phone: _____

### Current Living Situation

☐ Family ☐ Independent ☐ Unhoused ☐ Group home ☐ Transitional living
Is this a stable/safe situation for patient/others to which they can return? ☐ Yes ☐ No ☐ Don't Know

Details:

### Information Submitted By

Name: Relationship to Patient:
Address: Phone: ( ) -

☐ Check if you are the applicant on petition ☐ Check if you are a witness on petition

**Signature** _____ **Date** _____

*Under the Arizona statute governing the involuntary evaluation and admission process (A.R.S. § 36-515B), any person "who knowingly makes a false statement of a material fact with the intent to cause another to be confined under this chapter is guilty of a class 1 misdemeanor."*

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|---|---|
| | **Phone: _____** |

## History of Patient's Symptoms and Behaviors

Please indicate symptoms or behaviors that the patient has had in *past* when their mental health condition is worsening ("Past"), and which ones you are observing with the patient *now* ("Now"). If you have *never* observed a symptom or behavior with the patient, please indicate "Never".

| Symptom or Behavior | Past | Now | Never |
|---|---|---|---|
| Suicide gesture(s)/attempt(s) | ☐ | ☐ | ☐ |
| Suicidal statements | ☐ | ☐ | ☐ |
| Suicide preparation (ie. stockpiling meds, giving away possessions, etc.) | ☐ | ☐ | ☐ |
| Cutting self/intentional self-injury | ☐ | ☐ | ☐ |
| Threats to others | ☐ | ☐ | ☐ |
| Physical aggression towards others | ☐ | ☐ | ☐ |
| Property destruction | ☐ | ☐ | ☐ |
| Stalking/obsession with another person | ☐ | ☐ | ☐ |
| Sexual preoccupation, or sexually inappropriate behaviors | ☐ | ☐ | ☐ |
| Fire setting | ☐ | ☐ | ☐ |
| Argumentativeness | ☐ | ☐ | ☐ |
| Anxiety/fearfulness | ☐ | ☐ | ☐ |
| Hypervigilance | ☐ | ☐ | ☐ |
| Suspiciousness/paranoia | ☐ | ☐ | ☐ |
| Irrational thoughts | ☐ | ☐ | ☐ |
| Speaking in a way others cannot follow/understand | ☐ | ☐ | ☐ |
| Hearing voices/talking to self | ☐ | ☐ | ☐ |
| Exhibiting emotions not appropriate to situation | ☐ | ☐ | ☐ |
| Expressing beliefs not consistent with reality | ☐ | ☐ | ☐ |
| Believes that someone is not who they say they are/is an impostor | ☐ | ☐ | ☐ |
| Sleeping excessively | ☐ | ☐ | ☐ |
| Decreased sleeping and looking tired | ☐ | ☐ | ☐ |

| Symptom or Behavior | Past | Now | Never |
|---|---|---|---|
| Eating excessively/noticeable weight gain | ☐ | ☐ | ☐ |
| Eating less/not eating/noticeable weight loss | ☐ | ☐ | ☐ |
| Decreased motivation | ☐ | ☐ | ☐ |
| Isolating self from others | ☐ | ☐ | ☐ |
| Crying/appearing sad | ☐ | ☐ | ☐ |
| Unable to concentrate | ☐ | ☐ | ☐ |
| Expressing feelings of worthlessness/being a burden to others/guilt | ☐ | ☐ | ☐ |
| Not attending to hygiene | ☐ | ☐ | ☐ |
| Talking less/quieter than usual | ☐ | ☐ | ☐ |
| Increased irritability | ☐ | ☐ | ☐ |
| Increased impulsivity (quitting job, spending money excessively, etc.) | ☐ | ☐ | ☐ |
| Decreased sleeping and NOT appearing tired | ☐ | ☐ | ☐ |
| Talking too fast or too much | ☐ | ☐ | ☐ |
| Emotions are intense and vary moment to moment, often without clear cause | ☐ | ☐ | ☐ |
| Increase in activity/movement | ☐ | ☐ | ☐ |
| Substance use/abuse | ☐ | ☐ | ☐ |
| Taking more medication than prescribed | ☐ | ☐ | ☐ |
| Not taking medications | ☐ | ☐ | ☐ |
| Not attending doctors' appointments | ☐ | ☐ | ☐ |
| Running away/cutting off contact | ☐ | ☐ | ☐ |



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**If you would like to provide additional details to any item above, please do so here:**

**If you ever feel afraid of the patient, please indicate here and explain what is making you feel this way:**

**Please describe recent history and behaviors that indicate dangerousness to self, dangerousness to others and/or make the patient unable to care for themselves:**

**Please describe what the patient looks like when they are doing "well" and when this was last the case**:

**Does patient have access to weapons?** ☐ Yes ☐ No ☐ Don't Know

Details:

**Does patient have access to other lethal means of suicide (pills, etc.)?** ☐ Yes ☐ No ☐ Don't Know

Details:

**If the answer to either of the above is 'Yes,' can the items be secured?** ☐ Yes ☐ No ☐ Don't Know

Details:

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**Indicate whether the patient can perform the following activities independently, or with assistance or prompting from another person, to the best of your knowledge:**

| **Activity** | **Performs Independently** | **Performs with prompting** | **Requires assistance** | **Performs more independently when doing "well"** |
|---|---|---|---|---|
| Bathing | ☐ | ☐ | ☐ | ☐ |
| Dressing | ☐ | ☐ | ☐ | ☐ |
| Toileting | ☐ | ☐ | ☐ | ☐ |
| Transferring (moving in and out of bed/chair) | ☐ | ☐ | ☐ | ☐ |
| Feeding | ☐ | ☐ | ☐ | ☐ |
| Shopping | ☐ | ☐ | ☐ | ☐ |
| Cooking | ☐ | ☐ | ☐ | ☐ |
| Taking medications as prescribed | ☐ | ☐ | ☐ | ☐ |
| Communicating needs | ☐ | ☐ | ☐ | ☐ |
| Managing finances (paying bills, budgeting) | ☐ | ☐ | ☐ | ☐ |
| Grocery shopping | ☐ | ☐ | ☐ | ☐ |
| Household cleaning | ☐ | ☐ | ☐ | ☐ |
| Making and returning phone calls | ☐ | ☐ | ☐ | ☐ |
| Transportation (driving a car, calling a cab, using public transportation) | ☐ | ☐ | ☐ | ☐ |

**Please provide any clarifying details needed for the above responses**:

**Please provide any advice/tips/insights that could help us provide better care to the patient:**