Safety Plan Worksheet

Patient Information

Name: _____ Date of Birth: __ Date: _ Provider: ____ Emergency Contact: ____ Emergency Contact Phone: ___ Relationship: ____

Step 1: Warning Signs/Triggers

What thoughts, images, moods, situations, or behaviors signal that a crisis may be developing? 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Step 2: Internal Coping Strategies

What can I do by myself to take my mind off my problems or help me cope when I experience the warning signs? 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Step 3: Social Contacts Who Can Provide Distraction

Who can I call or visit to take my mind off my problems? 1. Name: ____ **Phone: __** Relationship: __ **2. Name:** ____ Phone: __ **Relationship:** __ 3. Name: ____ **Phone: __** Relationship: _____

Step 4: Social Contacts Who Can Provide Support

Who can I call or visit who may be able to help resolve a crisis? 1. Name: ____ **Phone: __** Relationship: __ **2. Name:** ____ Phone: __ **Relationship:** __ 3. Name: ____ **Phone: __** Relationship: _____

Step 5: Professional and Agency Contacts

Who are the mental health professionals I can contact during a crisis? 1. Clinician Name: ____ **Phone:** __ Hours: __ **2. Clinician Name:** ___ Phone: __ **Hours:** __ 3. Local Urgent

Care Services: _____ **Phone:** _____ 4. Local Emergency Department: _____ **Address:** ___

Step 6: Making the Environment Safe

What items should be removed or secured to make my environment safer? 1. _____ 2. _____ 3. _____ 4. _____

Crisis Resources (Available 24/7)

- **National Suicide Prevention Lifeline**: 988 or 1-800-273-8255
- **Crisis Text Line**: Text HOME to 741741
- **Veterans Crisis Line**: 988, press 1 or 1-800-273-8255, press 1
- **Trans Lifeline**: 1-877-565-8860
- **Trevor Project (LGBTQ+)**: 1-866-488-7386
- **Local Crisis Line**: _____

My Reasons for Living

What are the most important things in my life, or hopes for the future, that are worth living for? 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Personal Commitment

I, _____, agree to use this plan when I notice my warning signs. I will do my best to keep myself safe and contact the individuals listed above if I need help.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Plan Review Dates

This safety plan should be reviewed and updated regularly.

Review Date: ___ **Patient Initials: _ Provider Initials: _ Review Date: __ Patient Initials: _ Provider Initials: _ Review Date: _ Patient Initials: _ Provider Initials: ____**