Guidelines for Individuals/Families for Completing Supplements to the Safety Plan or Advance Communication Documents

There are four pre-formatted documents (or 'supplements') available to help you summarize the kind of information that is often requested by treatment agencies. In a crisis situation, it can be difficult and time consuming to remember important medical information, treatment history, names, and phone numbers.

The four documents cover the following information:
- Summary of Medical Information
- Summary of Prior Treatment/Personal Demographic Information
- Summary of Current Services
- Summary of School, and/or Work

How the forms are used:
- You can choose to complete any or all of the documents.
- You do not have to complete every section—it is your choice to decide what is important to communicate.
- These documents can be attached to the Safety Plan or Advance Communication that is sent to_____.
- Additionally, you can substitute an alternate summary document to use as a supplement.
- If you find one or more of the supplements useful, but do not wish to complete a Safety Plan or Advance Communication, that is okay too—choose what you think will work best for you. You can always complete different forms at a later date.

Note that if you are completing the supplements online you cannot save the document. Be sure to print before closing the document.

Personal Demographic Information

INFORMATION ABOUT PERSON RECEIVING SERVICES

Address_____

_____

City_____ Province_____ Postal Code _____

Home phone _____ Cell phone_____ Work phone _____

Type of living arrangement _____

_____

Gender _____ Date of birth _____ / _____ / _____

Health Card # _____ Version Code_____ Expiry Date _____/_____ / _____

Notes/Alerts: _____

5099c/01-2015

INFORMATION ABOUT PARENT(S), GUARDIAN(S) OR SPOUSE/SIGNIFICANT OTHER ❑ NOT APPLICABLE

Name _____

Relationship _____ Living with? ❑ Yes ❑ No

Address _____

_____

City _____ Province _____ Postal Code _____

Home phone _____ Cell phone _____ Work phone _____

Notes: _____

_____

Name _____

Relationship _____ Living with? ❑ Yes ❑ No

Address _____

_____

City _____ Province _____ Postal Code _____

Home phone _____ Cell phone _____ Work phone _____

Notes: _____

_____

Name _____

Relationship _____ Living with? ❑ Yes ❑ No

Address _____

_____

City _____ Province _____ Postal Code _____

Home phone _____ Cell phone _____ Work phone _____

Notes: _____

_____

INFORMATION ABOUT FRIENDS, ADVOCATES, OR OTHER SUPPORTIVE PEOPLE

❑ NOT APPLICABLE

Name _____

Relationship _____ Living with? ❑ Yes ❑ No

Address _____

_____

City _____ Province _____ Postal Code _____

Home phone _____ Cell phone _____ Work phone _____

Notes: _____

_____

Name _____

Relationship _____ Living with? ❑ Yes ❑ No

Address _____

_____

City _____ Province _____ Postal Code _____

Home phone _____ Cell phone _____ Work phone _____

Notes: _____

_____

Name _____

Relationship _____ Living with? ❑ Yes ❑ No

Address _____

_____

City _____ Province _____ Postal Code _____

Home phone _____ Cell phone _____ Work phone _____

Notes: _____

_____

Summary of Medical Information

HEALTH CONDITIONS OR CONCERNS

Physical Health	Mental Health	Substance Use	Development

Notes:

List any special accommodations required due to physical condition or communication barrier:

MEDICATIONS

Name of Medication	Dosage	Current or Discontinued	Prescribed by	Note

ALLERGIES (MEDICATION, FOOD, OTHER)

Allergens	Mild Symptoms	Moderate Symptoms	Severe or Life Threatening	Notes

Summary of Prior Treatment

SUMMARY OF OUTPATIENT TREATMENT SERVICES (FROM MOST RECENT TO FIRST)

Date Treatment Began	Duration of Treatment	Agency/Program Name	Type of Treatment	Notes

SUMMARY OF HOSPITALIZATIONS/OUT OF HOME TREATMENT (FROM MOST RECENT TO FIRST)

Date of Admission	Length of Stay	Facility Name	Reason for Admission	Notes

Summary of Current Services

❑ Physical Health ❑ Mental Health ❑ Substance Use ❑ Concurrent ❑ Pharmacy ❑ Developmental Services ❑ Other ______

Provider ______________________________ Phone ______________

Address ______________________________

City ______________ Province ______________ Postal Code ______________

Notes ______________________________

❑ Physical Health ❑ Mental Health ❑ Substance Use ❑ Concurrent ❑ Pharmacy ❑ Developmental Services ❑ Other ______

Provider ______________________________ Phone ______________

Address ______________________________

City ______________ Province ______________ Postal Code ______________

Notes ______________________________

❑ Physical Health ❑ Mental Health ❑ Substance Use ❑ Concurrent ❑ Pharmacy ❑ Developmental Services ❑ Other ______

Provider ______________________________ Phone ______________

Address ______________________________

City ______________ Province ______________ Postal Code ______________

Notes ______________________________

❑ Physical Health ❑ Mental Health ❑ Substance Use ❑ Concurrent ❑ Pharmacy ❑ Developmental Services ❑ Other ______

Provider ______________________________ Phone ______________

Address ______________________________

City ______________ Province ______________ Postal Code ______________

Notes ______________________________

Summary of School/Work Information

INFORMATION ABOUT SCHOOL

❑ NOT APPLICABLE ❑ DO NOT CONTACT

School name _____ Grade _____

Program type _____

Preferred contact #1 _____

Title _____ Phone _____

Preferred contact #2 _____

Title _____ Phone _____

INFORMATION ABOUT WORK

❑ NOT APPLICABLE ❑ DO NOT CONTACT

Name of business _____

Job title _____ Phone _____

Preferred contact _____

Title _____ Phone _____

I want this plan to be shared with: _____*

*Note that if you want the provider to share this plan consent must be provided.