

**Crisis:**

**Suicide Postvention & Intake Forms**

**(English & Spanish)**

Education Services Student Support

Updated 1/7/19



# Clinician Resources

Local Counseling/Mental Health Support

|  |  |
| --- | --- |
| **Bay Area Community Resources**  [https://ww](http://www.bacr.org/)w.bacr.o[rg/](http://www.bacr.org/) | Counseling Clinic (415) 444-5580 |
| **North Marin Community Services**  [https://ww](http://www.northmarincs.org/)w.[northmarinc](http://www.northmarincs.org/)s.org/ | (415) 892-1643 x239 (Se habla Espanol) |
| **Novato Teen Clinic**  North Marin Community Services 6090 Redwood Blvd | Wednesday, 1:30- 5pm drop-in  (415) 985-5012 (call or text) |
| **Buckelew Programs**  <http://www.buckelew.org/> | (415) 457-6964  Buckelew Counseling Services Intake Line: (415) 491-5716 |
| **The Spahr Center**  https://thespahrcenter.org/ | thespahrcenter.org  *LGBTQ Youth Drop-in Groups* (Novato, 1st and 3rd Weds, 5- 6:30)  *Groupo de Acogida Juvenil* (San Rafael, 2nd and 4th Weds, 5- 6:30) |
| **Marin Community Clinic**  6100 and 6090 Redwood Blvd  Novato 94945 [https://ww](http://www.marinclinic.org/)w.marin[clinic.org/](http://www.marinclinic.org/) | (415) 448-1500 |
| **Center for Domestic Peace**  centerfordomesticpeace.org/ | English (415) 924-6616  Spanish (415) 924-3456  ManKind (415) 924-1070  Marin Youth Services  Text Line 415.526.2557; M-F, 9am-5pm |

Crisis Support

|  |  |
| --- | --- |
| **North Bay Suicide Prevention**  toll free 24/7 crisis hotline | In Marin: (415) 499-1100  In Sonoma, Lake and Mendocino County, call 1-855-587-6373 |
| **Crisis Stabilization Unit (Marin General)**  available 24/7 | (415) 473-6666 |
| **Mobile Crisis Response Team (MCRT)**  Mon-Sat 1pm-9pm | 415-473-6392  415-473-3344 TTY |
| **National Suicide Prevention Lifeline**  available 24/7 | 1-800-273-8255;  (Se habla Espanol) 1-888-628-9454 |
| **TrevorLifeline**  available 24/7 | 1-866-488-7386 |
| **Crisis Text Line**  available 24/7; [www.crisistextline.org/](http://www.crisistextline.org/) | text HELLO to 741741 |

**STUDENT NAME: DOB: LOCATION: DATE: INTERVENER NAME: ROLE:**

|  |  |  |
| --- | --- | --- |
| Triggers |  | Warning Signs |
| There are certain situations or circumstances which make me feel uncomfortable and/or agitated: |  | I should use my safety plan when I notice these warning signs (thoughts, images, moods, situations, behaviors): |
| 1. |  | 1. |
| 2. |  | 2. |
| 3. |  | 3. |

|  |  |  |
| --- | --- | --- |
| Coping Skills/Healthy Behaviors |  | Places I Feel Safe |
| Things I can do to calm myself down or feel better in the  moment (e.g. favorite activities, hobbies, relaxation techniques): |  | Places that make me feel better and make me feel safe  (can be a physical location, an imaginary happy place, or refer in the presence of safe people): |
| 1. |  | 1. |
| 2. |  | 2. |
| 3. |  | 3. |

|  |  |  |
| --- | --- | --- |
| School Support |  | Adult Support |
| Healthy adults at school and/or ways school staff can give me support: |  | Healthy adults at home or in my community, whom I trust and feel comfortable asking for help during a crisis (include phone number): |
| 1. |  | 1. |
| 2. |  | 2. |
| 3. |  | 3. |

|  |  |  |
| --- | --- | --- |
| Parent Support |  | Case Carrier Support |
| Actions my parent/guardian can take to help me stay safe: |  | Actions my case carrier can take to help me stay safe: |
| 1. |  | 1. |
| 2. |  | 2. |
| 3. |  | 3. |

**Outside Mental Health Agency Providing Me Support**

Mental Health Agency: Clinician Name:

Office #: Cell #: Clinician Email:

During a crisis, I can also:

* Text 741-741 any time of day
* Call 911 For Immediate Support
* Call Marin County Mobile Crisis Response Team (MCRT) at (415) 473-6392 between 1pm & 9pm.
* Suicide Prevention Lines (24 Hours)
  + National Suicide Prevention Lifeline (800) 273-TALK or (800) 273-8255
  + Suicide Prevention Crisis Line (877) 727-4747
  + National Hopeline Network (800) SUICIDE or (800) 784-2433
  + California Youth Crisis Line (800) 843-5200 –**bilingual**
* Call TEEN LINE (800) TLC-TEEN
  + Teen-to-teen hotline with community outreach services, from 6pm-10pm PST daily.
  + Text, email, and message board also available, with limited hours-visit [http://teenlineonline.org](http://teenlineonline.org/) for more information.
* The Trevor Project (866) 4-U-TREVOR or (866) 488-7386 –
  + 24 hour crisis line that provides crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13-24. Text and chat also available, with limited hours-visit [www.thetrevorproject.org](http://www.thetrevorproject.org/) for more information.

**Verifications:**

|  |  |
| --- | --- |
| Student Signature | Date |
| Parent/Guardian Name (please print) | Phone# |
| Parent /Guardian Signature | Date |
| Administrator/Case Carrier (please print) | Title |
| Administrator/Case Carrier Signature | Date |
| Other/Title | Date |

**NOMBRE DEL ALUMNO:**

**FECHA DE NACIMIENTO: FECHA: LUGAR:**

**NOMBRE DE QUIEN INTERVIENE: ROL:**

|  |  |  |
| --- | --- | --- |
| Detonantes |  | Señales de advertencia |
| Hay ciertas situaciones o circunstancias que me hacen sentir incómodo(a) y/o agitado(a): |  | Debo usar mi plan de seguridad cuando note estas señales de advertencia (pensamientos, imágenes,  estados de ánimo, situaciones, comportamientos): |
| 1. |  | 1. |
| 2. |  | 2. |
| 3. |  | 3. |

|  |  |  |
| --- | --- | --- |
| **Habilidades para enfrentar la situación/Comportamientos saludables** |  | **Lugares en los que me siento seguro(a)** |
| Cosas que puedo hacer para calmarme o sentirme mejor en el momento (por ejemplo, actividades favoritas,  pasatiempos, técnicas de relajación): |  | Lugares que me hacen sentir mejor y seguro(a) (puede ser un lugar físico, un lugar feliz imaginario o lugares  donde encuentro la presencia de personas seguras): |
| 1. |  | 1. |
| 2. |  | 2. |
| 3. |  | 3. |

|  |  |  |
| --- | --- | --- |
| **Apoyo en la escuela** |  | **Apoyo de adultos** |
| Adultos en la escuela y/o maneras en que el personal de la escuela puede darme apoyo |  | Adultos en mi casa o en la comunidad, en quienes puedo  confiar y sentirme a gusto para pedirles ayuda durante una crisis (incluye su número de teléfono): |
| 1. |  | 1. |
| 2. |  | 2. |
| 3. |  | 3. |

|  |  |  |
| --- | --- | --- |
| **Apoyo del padre o tutor** |  | **Apoyo del encargado de caso** |
| Acciones que pueden tomar mis padres o tutores para ayudarme a sentirme seguro(a): |  | Acciones que puede tomar la persona a cargo de mi caso para ayudarme a sentirme seguro(a): |
| 1. |  | 1. |
| 2. |  | 2. |
| 3. |  | 3. |

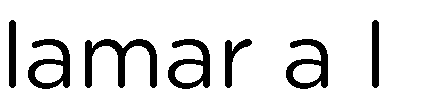
**Agencia de salud mental externa que me proporciona apoyo**

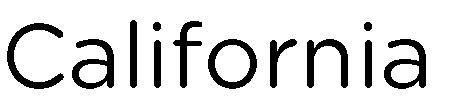
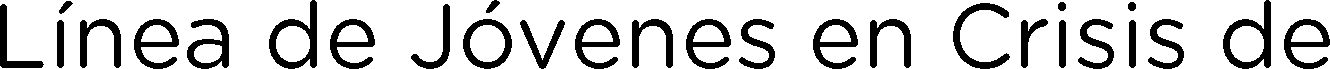
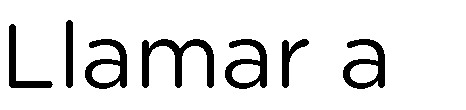
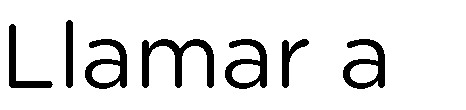
**Agencia de salud mental: Nombre del(a) terapeuta: # de Oficina: # de Celular: Correo electrónico del(a) terapeuta:**

Durante una crisis, también puedo:

* Mandar un texto al 741-741 a cualquier hora del día
* Llamar al 911 para apoyo inmediato
* Llamar al Equipo de respuesta a crisis del condado *Marin County Mobile Crisis Response Team* (MCRT) al (415) 473-6392 de lunes a sábado, entre 1pm y 9pm.

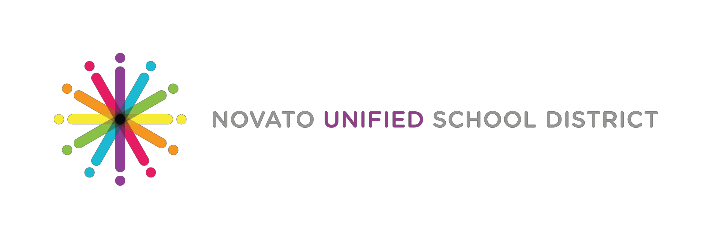
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* + Línea Nacional de Prevención del Suicidio (888) 628-9454 Español
  + Línea de Prevención del Suicidio (877) 727-4747 Bilingüe
  + (800) 843-5200 Bilingüe
* *TEEN LINE* (800) TLC-TEEN
  + Una línea telefónica entre adolescentes con servicios comunitarios, de 6pm a 8pm PST diariamente.
  + También están disponibles textos, correo electrónico y pizarra de mensajes, en horarios limitados. Para obtener más información visita [http://teenlineonline.org](http://teenlineonline.org/)
* *The Trevor Project* (866) 4-U-TREVOR or (866) 488-7386
  + Una línea de crisis que funciona las 24 horas y que proporciona servicios de intervención de crisis y de prevención del suicidio a jóvenes gay y lesbianas, bisexuales, transgénero y quienes están cuestionando (LGBTQ) de 13 a 24 años. Texto y chat también están disponibles en horarios limitados. Para obtener más información visita [www.thetrevorproject.org](http://www.thetrevorproject.org/)

**Verificaciones:**

|  |  |
| --- | --- |
| Firma del alumno(a) | Fecha |
| Nombre del padre o tutor legal (por favor use letra de molde) | Teléfono |
| Firma del padre o tutor legal | Fecha |
| Administrador/Encardado del caso (por favor use letra de molde) | Titulo |
| Firma del Administrador/Encardado del caso | Fecha |
| Otro/Puesto | Fecha |



**STUDENT RE-ENTRY CHECKLIST**

Student Name: DOB:

School:\_ \_Date:

In planning for the re-entry of a student who has been out of school for any length of time following reported suicidal ideation, including mental health hospitalization, or if the student will be transferring to a new school, the school site administrator/designee may consider any of the following action items:

|  |  |
| --- | --- |
| **Preparing for Re- Entry** | If a student has been out of school for any length of time, including for a mental health evaluation or mental health hospitalization, including psychiatric and drug or alcohol inpatient treatment, consider providing the parent “Return to School Information for Parent/Guardian”, which outlines steps to facilitate a positive transition back to school. |
| **Returning Day** | Have parent/guardian escort student to the main office on first day back to school. |
| **Hospital Discharge Documents** | Request discharge documents from hospital or Medical Clearance for Return to School from parent/guardian on student’s first day back. |
| **Meeting with Parent(s)/ Guardian(s)** | Engage parent(s)/guardian(s), school support staff, teachers, and student, as appropriate in a Re-Entry Planning Meeting.  If the student is prescribed medication, monitor with parent/guardian consent. Offer suggestions to parent/guardian regarding safety planning and removing means/access (e.g., weapons, medication, alcohol) to students at home, as needed. Offer suggestions to parent/guardian regarding monitoring personal communication devices, including social networking sites, as needed.  Review *Suicide Prevention Awareness for Parents/Caregivers* with caregiver. |
| **Student Safety Plan** | As appropriate, develop a Safety Plan to assist the student in identifying adults they trust and can go to for assistance at school and outside of school (e.g., home, community). See “Student Safety Plan”. |
| **Identify Supports** | Notify student’s teacher(s), as appropriate. Modify academic programming, as appropriate.  Consider an assessment for special education for a student whose behavioral and emotional needs affect their ability to benefit from their educational program Identify on-going mental health resources in school and/or in the community Designate staff (e.g., Psychiatric Social Worker, Pupil Services and Attendance,  Counselor, School Nurse, Academic Counselor) to check in with the student during the first couple weeks periodically.  Manage and monitor – ensure the student is receiving and accessing the proper mental health and educational services needed. |
| **Address Bullying,**  **Harassment, Discrimination** | As needed, ensure that any bullying, harassment, discrimination is being addressed. |
| **Release/Exchange of Information** | Obtain consent by the parent/guardian to discuss student information with outside providers using the Parent/Guardian Authorization for Release/Exchange of Information. |

Date: School:

RE:

Student Name and DOB:

Dear Parent/Guardian:

The following steps have been outlined to help facilitate a positive transition back to school after your child returns from a psychiatric evaluation. Please review the checklist below prior to your child’s return to school:

* Communicate with:

 Principal and/or

 School Site Crisis Team member

Regarding whether your child was hospitalized (in-patient), following a psychiatric evaluation. If hospitalized, please notify the school of the name of the hospital.

Principal Name School Phone Number To Call

School Site Crisis Team Member Name School Phone Number To Call

* Request discharge documents from the hospital OR Have the hospital complete the Medical Clearance for Return to School form (attached).

 Ensure the hospital includes any accommodations/recommendations requested.

* If medication was prescribed, it is recommended that you inform the school nurse of medication(s) and dosage. However, if the student needs to have medication administered at school by the school nurse, then please be sure to complete and return the Authorization to Administer Medication.
* Inform the school contact person, indicated above, when your son/daughter will return to school.
* Escort your son/daughter to school on the first day back after the hospitalization.

 Please request to meet with

(Name of School Site Crisis Team Member)

located in .

(Office/Room #)

* Participate in your son/daughter’s Students Re-entry Meeting, which will include creating his/her Safety Plan.

Thank you for working with us to support your child at school.

Fecha:

Nombre de la escuela: RE:

Nombre del alumno(a) y fecha de nacimiento:

Estimado padre de familia o tutor:

Hemos subrayado los siguientes pasos para facilitar una transición positiva de regreso a la escuela para su hijo o hija, después de una evaluación psiquiátrica u hospitalización. Por favor, revise esta lista antes del regreso a la escuela de su hijo o hija:

* Comuníquese con

 el/la Director(a) y/o

 un miembro del equipo de crisis de la escuela

Respecto a si su hijo o hija fue hospitalizado(a) después de una evaluación siquiátrica. Si fue hospitalizado(a), por favor notifique a la escuela el nombre del hospital.

Nombre del(a) director(a) Número de teléfono de la escuela para llamar

Nombre del miembro del equipo de crisis de la escuela Número de teléfono de la escuela para llamar

* Solicite los documentos del alta del hospital o pídales que llenen el siguiente formulario de alta médica para regreso a la escuela (adjunto).

 Asegúrese de que el hospital incluya cualquier acomodo o recomendación solicitada.

* Si le recetaron algún medicamento, es recomendable que informe a la enfermera escolar el nombre y dosis del medicamento. Pero si su hijo o hija necesita que la enfermera escolar le administre el medicamento, por favor asegúrese de solicitar a su médico que llene los formularios requeridos.
* Informe a la persona indicada en este documento, de cuándo va a regresar su hijo o hija a la escuela.
* Acompañe a su hijo/a a la escuela el primer día que regrese después de la hospitalización.

 Por favor pida reunirse con localizado(a) en .

(Nombre del miembro del equipo de crisis) (Oficina/salón #)

* Participe en la reunión de regreso a la escuela de su hijo o hija, que incluye crear su Plan de seguridad.

Gracias por trabajar con nosotros para apoyar a su hijo o hija en la escuela.

Date: To Parent(s)/Guardian(s) of:

This document authorizes the release/exchange of information relating to my child between the agency personnel listed below and a representative of NUSD. Only appropriate professionals in accordance with the Family Educational Rights and Privacy Act of 1974 shall review the information received.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| TO: |  | | | RE: |  | | |
| Agency Staff Name/Title | |  | DOB: | Student Last Name | Student First Name | |
| Agency, Institution, or Department | | |  | Month | Day | Year |
| Street Address | | | Home Address: | | | |
| City | State | ZIP | City |  | State | Zip |
| Agency Phone Number | | | Home or Cell Phone Number | | | |

**I hereby give you permission to release/exchange the following information to assist in determining student needs:**

 Medical/Health  Speech & Language  Educational

 Psychological/Mental Health  Other – Specify:

**THIS INFORMATION IS TO BE SENT TO:**

School Staff Name Title/School or Office

School Address Phone Number

**This authorization shall be valid for one year from date of signature, unless otherwise identified or revoked.**

|  |  |  |  |
| --- | --- | --- | --- |
| *I request a copy of this authorization:* |  *Yes* |  *No* |  |
| Name of Parent/Legal Guardian |  | Phone Number |  |
| Signature of Parent/Legal Guardian |  | Date |  |

Fecha: A los padres o tutores de:

Este documento autoriza a divulgar e intercambiar información sobre su hijo o hija entre el personal de la agencia indicada y un representante del Distrito Escolar Unificado de Novato (NUSD). La información recibida será revisada únicamente por profesionales apropiados en acuerdo a los Derechos Educativos Familiares y la Ley de Privacidad de 1974.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| A: |  | RE: |  | |
| Nombre del personal de agencia/Puesto |  | Apellido del alumno(a)  Fecha de nacimiento: | Nombre del | alumno(a) |
| Agencia, Institución o Departamento |  |  | Mes/ | Día Año |
| Dirección |  | Dirección de su casa |  |  |
| Ciudad Estado | Código Postal | Ciudad | Estado | Código Postal |

**Por medio de la presente doy permiso para divulgar e intercambiar la siguiente información para determinar las necesidades del alumno(a):**

Número de teléfono de agencia

Número de teléfono de casa o celular

 Médica/de salud  Habla y Lenguaje  Educativa

 Sicológica o de salud mental  Otra- Especificar:

**ESTA INFORMACIÓN SERÁ ENVIADA A:**

Nombre de personal escolar Puesto/Escuela u oficina

Dirección de la escuela Número de teléfono

**Esta autorización será válida por un año a partir de la fecha de la firma, a menos que se indique de otra manera o que se revoque.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Requiero una copia de esta autorización:* |  *Sí* |  |  *No* |  |
| Nombre del padre o tutor legal |  |  | Número de teléfono |  |
| Firma del padre o tutor legal |  |  | Fecha |  |

Medical Clearance: Return to School

**Following Mental Health Intervention Services or Hospitalization CONFIDENTIAL**

Date:

Student Name: DOB: School: Grade:

Dear Doctor:

The student named above was either hospitalized or received mental health services recently for being a danger to him/herself, danger to others, and/or gravely disabled. Medical information from you is essential in planning for the student’s safety, educational, and health needs.

Please complete the following information and return to the parent/guardian to provide to the school upon his or her return to school. Your cooperation is greatly appreciated.

If the student no longer poses a threat to self and/or others at the time of discharge and can return to school, please sign below and indicate restrictions, if any.

The above named student does not pose a threat to self and/or others at the time of discharge and may return to school:

 Without restrictions

 With the modifications/restrictions indicated below:

|  |  |
| --- | --- |
| Recommended Modifications/Restrictions | Prescribed medications and dosages: |

Doctor’s Name Doctor’s Signature

Hospital Name Contact Number

**Authorization to Exchange/Release Medical Information**

**TO: RE:**

Practitioner/Staff Name/Title Student Last, First Name

Hospital/Agency/Clinic DOB: Month/Day/Year

I hereby give you permission to release/exchange the following information:

 Medical/Health  Speech & Language  Psychological/Mental Health

 Other – Specify:

Name of Parent/Legal Guardian Signature of Parent/Legal Guardian Date

Autorización médica: Regreso a la escuela después de recibir servicios de intervención de salud mental o de una hospitalización CONFIDENCIAL

Fecha:

Nombre del(a) alumno(a): Fecha de nacimiento: Escuela: Grado: Estimado(a) Doctor(a):

El alumno(a) nombrado(a) en este documento fue hospitalizado(a) o recibió servicios de salud mental recientemente por representar un peligro a sí mismo(a), para los demás y/o por estar gravemente discapacitado(a). La información médica que usted brinde es esencial en la planificación de las necesidades de seguridad, educativas y de salud del(a) alumno(a).

**Por favor, complete la siguiente información y entréguesela al padre o tutor para que pueda dársela a la escuela cuando el/la alumno(a) regrese. Su cooperación es altamente apreciada.**

Si el/la alumno(a) nombrado(a) en este documento ya no representa una amenaza para sí mismo(a) o para otras personas en el momento en que fue dado(a) de alta y ya puede regresar a la escuela, por favor firme e indique cualquier restricción, si es que la hay.

El/la alumno(a) nombrado(a) no representa una amenaza para sí mismo(a) o para otras personas en el momento en que fue dado(a) de alta y puede regresar a la escuela:

 Sin restricciones

 Con la(s) siguiente(s) modificación(es)/restricción(es):

|  |  |
| --- | --- |
| Modificaciones o restricciones recomendadas: | Indique cualquier medicamento prescrito y la dosis: |

Nombre del(a) doctor(a) Firma del(a) doctor(a)

Nombre del hospital Número de contacto

**AUTORIZACIÓN PARA DIVULGAR E INTERCAMBIAR INFORMACIÓN MÉDICA**

**A: RE:**

Nombre del personal de la agencia/Puesto Primer nombre y apellido del alumno(a)

Agencia, Institución o Departamento Fecha de nacimiento: mes/día/año

Por medio de la presente doy permiso para divulgar e intercambiar la siguiente información:

 Médica/de salud  de habla y lenguaje  Sicológica/de salud mental

 Otra Cosa (especifique):

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date: |  | | | | | | |  | | | | |
| Student Name: |  | | | | | | | DOB: | |  | | |
| School: |  | | | | | | | Grade: | |  | | |
| Parent/Guardian Name: | |  | | | | | | Phone Number: | | |  | |
|  | | | | | | | | | | | | |
| **Assessed Level of Risk Upon Return:** | | | | | * Low | | * Moderate | | | * High | |  |
|  | | | | | | | | | | | | |
| **Background/Relevant History** *(include strengths, concerns, current issues, past suicide attempts, prior hospitalizations (5150/5585), history of self-injury, mental health history)* | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Medications *(List Name, dosage, and prn)* | | | |  | | | | | | | | |
| Recent Medication Change? | | |  | * Yes |  |  | * No | |  |  | * Unknown | |
| Medication Compliant? | |  |  | * Yes |  |  | * No | |  |  | * Unknown | |
|  | | | | | | | | | | | | |
| **Other Factors to Consider** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Current Mental Health Support: | | | Agency: | |  | | | | Clinician Name: | | |  |
| Office Phone: | | | Cell Phone: | | |  | | | Email: | | |  |
| Student MRN: *(if applicable)* | | |  | | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Recent Hospitalization? | * Yes ☐No ☐Unknown | | |
| Discharge Summary: |  | | |
|  | | | |
| Supportive Adults at school (List all relevant individuals) |  | | |
| Outside supports (*List all*) |  | | |
| Support Plan: |  | | |
|  | | | |
| Home/School Communication Plan: | Contact Information: | Content: | Frequency: |
|  |  |  |  |
| Follow-Up (*as appropriate*): |  | | |

In attendance:

\_ Signature Print Name/Title

\_ Signature Print Name/Title

\_ Signature Print Name/Title

\_ Signature Print Name/Title

\_ Signature Print Name/Title

\_ Signature Print Name/Title

\_ Signature Print Name/Title

\_ Signature Print Name/Title

\_ Signature Print Name/Title

\_ Signature Print Name/Title

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| Date: | Click or tap here to enter text. | | | | | | | |  | | | | | |
| Student Name: | Click or tap here to enter text. | | | | | | | | DOB: | | | Click or tap here to enter text. | | |
| School: | Click or tap here to enter text. | | | | | | | | Grade: | | | Click or tap here to enter text. | | |
| Parent/Guardian Name: | | Click or tap here to enter text. | | | | | | | Phone Number: | | | | Click or tap here to enter text. | |
|  | | | | | | | | | | | | | | |
| Assessed Level of Risk Upon Return: | | | |  |  | * Low | | * Moderate | | | | * High | |  |
|  | | | | | | | | | | | | | | |
| **Background/Relevant History** *(include strengths, concerns, current issues, past suicide attempts, prior hospitalizations (5150/5585), history of self-injury, mental health history)* | | | | | | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | | | | | | |
| Medications *(List Name, dosage, and prn)* | | | | | Click or tap here to enter text. | | | | | | | | | |
| Recent Medication Change? | | |  |  | * Yes |  |  | * No | |  |  |  | * Unknown | |
| Medication Compliant? | |  |  |  | * Yes |  |  | * No | |  |  |  | * Unknown | |
|  | | | | | | | | | | | | | | |
| **Other Factors to Consider** | | | | | | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | | | | | | |
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| Current Mental Health Support: | | | Agency: | | | Click or tap here to enter text. | | | | Clinician Name: | | | | Click or tap here to enter text. |
| Office Phone: Click or tap here to enter text. | | | Cell Phone: | | | | Click or tap here to enter text. | | | | Email: | | | Click or tap here to enter text. |
| Student MRN: *(if applicable)* | | | Click or tap here to enter text. | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Recent Hospitalization? | | | * Yes ☐No ☐Unknown | | | | | | | | | | | |
| Discharge Summary: | | | Click or tap here to enter text. | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Supportive Adults at school (List all relevant individuals) | | | Click or tap here to enter text. | | | | | | | | | | | |
| Outside supports (*List all*) | | | Click or tap here to enter text. | | | | | | | | | | | |
| Support Plan: | | | Click or tap here to enter text. | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Home/School Communication Plan: | | | | Contact Information: | | | | Content: | | | | | | Frequency: |
|  | | | | Click or tap here to enter text. | | | | Click or tap here to enter text. | | | | | | Click or tap here to enter text. |
| Follow-Up (*as appropriate*): | | | Click or tap here to enter text. | | | | | | | | | | | |

In attendance:

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\_ Signature Print Name/Title

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# Important Contacts

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| Name | Role | Phone | Email |
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#### NOVATO RESOURCE GUIDE FOR MENTAL HEALTH RESOURCES

Prepared for Novato Unified School District, Children/Teens and their Parents and Caregivers, 2017

It is difficult at times to know if the behavior you are seeing in yourself, your child or teen is a part of growing up, or is a result of challenges or changes happening in the family or environment. Children and teens may either “act out” or “act in” when faced with stressful or challenging situations. The most common contributors are changes in the family (divorce, death, illness, loss of housing or unemployment, new baby, a parent’s new partner or a new caregiver) or changes in the child/teens environment (housing, schools, friends, teachers and so forth).

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| --- | --- | --- |
| **ARE YOU NOTICING ANY OF THE FOLLOWING TROUBLESOME BEHAVIORS?** | | |
| * Talking back * Refusing to follow the rules * Difficulty paying attention * Frequent fights verbal and/or physical * Disruptive around others * Expressing thoughts of hurting themselves or others * Acting on thoughts of hurting   themselves | * Using substances or alcohol * Withdrawing from friends and/or adults * Crying * Fear of separation * Frequent bad dreams * Writing or drawing about scary, or violent things * Running away | * Acting younger than they normally do * Angry outbursts * Temper tantrums * Bedwetting when there was no difficulty before * Clinging * Irritability |

**STEPS YOU CAN TAKE:**

* For an emergency mental health crisis, please call (415) 473-6666 or 911.
* Contact your child/teen’s doctor, insurance company, or health care provider for information.
* Talk to your school administrator about school-based counseling services available.
* Contact a mental health provider (see list below for sliding scale and affordable options).

**PROFESSIONAL MENTAL HEALTH SUPPORT RESOURCES IN NOVATO**

**North Marin Community Services, Mental Health Programs**

For children, teens and their families. English and Spanish counselors available. Affordable fees ($30/session).

Call (415) 892-1643 ext 239 for a free, confidential assessment.

Visit [www.northmarincs.org,](http://www.northmarincs.org/) clinic located at 680 Wilson Avenue, Novato

**Novato Teen Clinic, Mondays 1:30-5pm**

Free counseling for teens ages 12-21. Teens can meet with a counselor by dropping in from 1:30-5pm each Monday. No appointment necessary. English and Spanish counselors available.

Call or text (415) 985-5012 or visit [www.northmarincs.org,](http://www.northmarincs.org/) Clinic located in Marin Community Clinics building at 6090 Redwood Blvd (look for the door with the green star).

**Marin Community Clinics**

For children, teens and their families. English and Spanish counselors available. Affordable fees (sliding scale), MediCal accepted.

Call (415) 448-1500 or visit [www.marinclinic.org,](http://www.marinclinic.org/) clinic located at 6100 Redwood Boulevard, Novato

**Other County-wide Services, call 211 for a complete Bay Area listing:** Bay Area Community Resources (BACR), [www.bacr.org,](http://www.bacr.org/) (415) 444-5580 Family Service Agency, [www.fsamarin.org,](http://www.fsamarin.org/) (415) 491-5700

Huckleberry Youth Programs, [www.huckleberryyouth.org,](http://www.huckleberryyouth.org/) Tuesday Teen Clinic (1-5 pm), (415) 386-9398 Partners Counseling Services, [www.drbassi.com,](http://www.drbassi.com/) (415) 497-0356



#### La Guía de Consejería de Salud Mental de Novato

Preparado para el Distrito Escolar Unificado de Novato para los niños, adolescentes y padres/guardianes, 2017

Algunas veces es muy difícil distinguir la causa de su propio comportamiento o el que usted ve en su niño o su adolescente, saber si es un producto del crecimiento normal o si es resultado de retos o cambios en relaciones de familia o del ambiente en que viven. Cuando los niños o adolescentes enfrentan dificultades o situaciones estresantes ellos pueden mostrar emociones inapropiadas portándose mal o guardándoselo por dentro. Las causas más comunes son los cambios en la familia (divorcio, muerte, enfermedades, pérdida de empleo o casa, un nuevo bebé, un nuevo padrastro, madrastra o pareja, cambio de persona que los cuide) o también cambios en el ambiente de los niños/jóvenes (vivienda, escuela, amistades, maestros, etc.

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| --- | --- | --- |
| **¿Está observando los siguientes comportamientos problemáticos?** | | |
| * Contestar mal * Negarse a respetar las reglas * Dificultad prestando atención * Peleándose seguido físicamente o verbalmente * Majadero con las personas alrededor * Expresar querer herir a otros o a sí mismo * Llegando a lastimarse a sí mismo | * Tomando alcohol u otras sustancias * Alejándose de amistades   y/o adultos   * Llorar * Miedo de separarse de la familia o de otros * Pesadillas frecuentes * Escribiendo o dibujando   cosas violentas o de miedo | * Huyendo de la casa * Comportándose más infantil de lo normal * Arranques de ira * Berrinches * Orinándose en la cama cuando no lo hacía antes * Estar muy pegado a uno físicamente * Irritable |

**ESTOS SON LOS PASOS QUE UD. DEBE SEGUIR:**

* En caso de emergencia de una crisis de salud mental, por favor **l**ame al (415) 473-6666 o al 911.
* Contacte al doctor de su niño/joven, compañía de seguro de salud o clínica para más información.
* Hable con los administradores de la escuela sobre cuáles servicios de consejería hay disponibles.
* Contactar a un profesional de salud mental (la guía siguiente lista servicios y opciones con flexibilidad de pagos).

**GUIA PARA AYUDA DE SERVICIOS PROFESIONALES DE SALUD MENTAL EN NOVATO**

**Programas de Salud Mental del North Marin Community Services**

Para niños, jóvenes y sus familias. Consejeros hablan inglés y español. Opciones para pagar y se acepta MediCal. Llame al (415) 892-1643 Ext. 239 para un asesoramiento gratis y confidencial.

Visite el [www.northmarincs.org,](http://www.northmarincs.org/) en el Internet. Las consultas son en el 680 Wilson Avenue, Novato. Precios accesibles ($30/por sesión).

**Clínica para jóvenes (Novato Teen Clinic) Lunes 1:30-5pm**

Consejería gratis para los jóvenes de 12 a 21 años. Los jóvenes pueden hablar con una consejera si nos visitan entre las 1:30pm y 5pm cada lunes. No se necesita una cita. Consejeras hablan inglés y español.

Llame o mándenos un texto (415) 985-5012 o visite nuestra página web [www.northmarincs.org,](http://www.novatoyouthcenter.org/) La clínica está ubicada en el edificio de Marin Community Clinics 6090 Redwood Blvd (busque la estrella verde en la puerta de la entrada de la clínica para jóvenes).

**Clínicas Comunitarias de Marín (Marin Community Clinics)**

Para niños, jóvenes y sus familias. Consejeras hablan inglés y español. Llame al (415) 448-1500 o visite el [www.marinclinic.org](http://www.marinclinic.org/) en el Internet. La clínica está localizada en el 6100 Redwood Boulevard, Novato.

**Otros servicios en el condado de Marín - llame al 211 para una guía completa del área de San Francisco:** Bay Area Community Resources (BACR), [www.bacr.org,](http://www.bacr.org/) (415) 444-5580

Family Service Agency, [www.fsamarin.org,](http://www.fsamarin.org/) (415) 491-5700

Huckleberry Youth Programs, [www.huckleberryyouth.org,](http://www.huckleberryyouth.org/) Clínica para los jóvenes los martes de 1-5 PM, (415) 386-9398 Partners Counseling Services, [www.drbassi.com,](http://www.drbassi.com/) (415) 497-0356