



Apache Behavioral Health Services, Inc.

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SUICIDE PREVENTION AND FAMILY INTERVENTION REFERRAL

PLEASE NOTE: IF THE PERSON IS IN IMMEDIATE DANGER OF SELF-HARM, PLEASE CALL 911 AND/OR TAKE HIM OR HER TO THE IHS ER.

DATE: _____ ORGANIZATION: _____

REFERRED BY: _____ PHONE: _____ FAX: _____

CLIENT NAME: _____ DOB /AGE: _____

PHONE NUMBER(s): WORK: _____ HOME: _____ CELL: _____

PHYSICAL ADDRESS: _____ COMMUNITY: _____

CONTACT PHONE # AT LOCATION: _____

PLEASE DESCRIBE LOCATION, UTILIZING LANDMARKS, CROSS STREETS, NEAREST NEIGHBOR, AND OTHER IMPORTANT INFORMATION.

FAMILY MEMBER NAME(S): _____

check here if legal guardian

CONTACT INFORMATION (IF DIFFERENT THAN ABOVE):

PHONE: _____ ADDRESS OR LOCATION DESCRIPTION: _____

REASON FOR REFERRAL: WHY ARE YOU CONCERNED THIS PERSON MAY HURT HIM OR HERSELF (please include date of incident if applicable)?

FOR SUICIDE PREVENTION AND INTERVENTION TEAM USE ONLY

Date _____ and time _____ received. Initials: _____

Efforts to contact: Dates, times, & initials: 1 _____ @ _____ 2 _____ @ _____ 3 _____ @ _____

Date of first contact: _____ Initials: _____ 2nd contact: _____ Initials: _____ 3rd contact: _____ Initials: _____