Appendix D: Provider Worksheets

Survivor Current Needs

Date: _____Provider: _____ Survivor Name: _____Location _____

This session was conducted with (check all that apply):
☐ Child ☐Adolescent ☐ Adult ☐Family ☐ Group

Provider: Use this form to document what the survivor needs most at this time. This form can be used to communicate with referral agencies to help promote continuity of care.

1. Check the boxes corresponding to difficulties the survivor is experiencing.

BEHAVIORAL	EMOTIONAL	PHYSICAL	COGNITIVE
Extreme disorientation	Acute stress reactions	Headaches	Inability to accept/cope with death of loved one(s)
Excessive drug, alcohol, or prescription drug use	Acute grief reactions	Stomachaches	Distressing dreams or nightmares
Isolation/withdrawal	Sadness, tearful	Sleep difficulties	Intrusive thoughts or images
High risk behavior	Irritability, anger	Difficulty eating	Difficulty concentrating
Regressive behavior	Feeling anxious, fearful	Worsening of health conditions	Difficulty remembering
Separation anxiety	Despair, hopeless	Fatigue/exhaustion	Difficulty making decisions
Violent behavior	Feelings of guilt or shame	Chronic agitation	Preoccupation with death/ destruction
Maladaptive coping	Feeling emotionally numb, disconnected	Other _____	Other _____
Other _____	Other _____		

2. Check the boxes corresponding to any other specific concerns

Past or preexisting trauma/psychological problems/substance abuse problems
Injured as a result of the disaster
At risk of losing life during the disaster
Loved one(s) missing or dead
Financial concerns
Displaced from home
Living arrangements
Lost job or school
Assisted with rescue/recovery
Has physical/emotional disability
Medication stabilization
Concerns about child/adolescent
Spiritual concerns
Other: _____

3. Please make note of any other information that might be helpful in making a referral.
_____
_____

4. Referral

Within project (specify) _____ ☐ Substance abuse treatment
Other disaster agencies ☐ Other community services
Professional mental health services ☐ Clergy
Medical treatment ☐ Other: _____

5. Was the referral accepted by the individual? ☐ Yes ☐ No