Appendix D: Provider Worksheets

Survivor Current Needs

	241 11 01 0		
Date:Provider:	Survivor Nar	ne:	Location
	ed with (check all that appl cent □ Adult □F		
Provider: Use this form	to document what the si	urvivor needs most at	this time. This form can be
used to communicate w	rith referral agencies to h	elp promote continuity	y of care.
1. Check the boxes corre	esponding to difficulties t	he survivor is experien	cino.
BEHAVIORAL	EMOTIONAL	PHYSICAL	COGNITIVE
Extreme	Acute stress reactions	Headaches	Inability to accept/cope
disorientation	Acute grief reactions	Stomachaches	with death of loved one(s)
Excessive drug,	Sadness, tearful	Sleep difficulties	Distressing dreams or
alcohol, or	Irritability, anger	Difficulty eating	nightmares
prescription drug use	Feeling anxious,	Worsening of	Intrusive thoughts or
Isolation/withdrawal	fearful	health conditions	images
High risk behavior	Despair, hopeless	Fatigue/exhaustion	Difficulty concentrating
Regressive behavior	Feelings of guilt or	Chronic agitation	Difficulty remembering
Separation anxiety	shame	Other	Difficulty making
Violent behavior	Feeling emotionally		decisions
Maladaptive coping	numb, disconnected		Preoccupation with death/
Other	Other		destruction
			Other
Injured as a result of a At risk of losing life of Loved one(s) missing Financial concerns Displaced from home Living arrangements Lost job or school Assisted with rescue/t Has physical/emotion Medication stabilizati Concerns about child. Spiritual concerns Other:	during the disaster or dead recovery lal disability ion /adolescent		
4. Referral	any other information th		
Within project (specify) Other disaster agencies		☐ Substance abuse treatment☐ Other community services	
Professional mental health services		☐ Chergy	
Medical treatment		☐ Clergy ☐ Other:	
		d Other.	
5. Was the referral accepted by the individual?		□ Yes □	No