Provider Worksheet

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
☐ Disorientation	☐ Acute stress reactions	☐ Headaches	☐ Inability to accept/ cope with death of loved one(s)
☐ Increased drug, alcohol, or prescription drug use	☐ Acute grief reactions	☐ Stomachaches	☐ Distressing dreams or nightmares
☐ Isolation/withdrawal	☐ Sadness, tearfulness	☐ Sleep difficulties	☐ Intrusive thoughts or images
☐ High-risk behavior	☐ Irritability, anger	☐ Difficulty eating	☐ Difficulty concentrating
☐ Regressive behavior	☐ Anxiety, fear	☐ Worsening of health conditions	☐ Difficulty remembering
☐ Separation anxiety	☐ Despair, hopelessness	☐ Fatigue/exhaustion	☐ Difficulty making decisions
☐ Violent behavior	☐ Guilt or shame	☐ Chronic agitation	☐ Preoccupation with death/destruction
☐ Maladaptive coping	☐ Feeling emotionally numb, disconnected	☐ Other ____________	☐ Difficulties completing assignments or chores
☐ Other ____________	☐ Other ____________		☐ Other ____________

2. Check the boxes corresponding to other specific concerns.

☐ Past or preexisting trauma/psychological problems/substance abuse problems

☐ Injured as a result of the emergency

☐ At risk of losing life during the emergency

☐ Loved one(s) missing or dead

☐ Displaced from home

☐ Assisted with rescue/recovery

☐ Pets missing/injured/dead

☐ Other________________________________

☐ Living arrangements

☐ Lost job or school

☐ Financial problems

☐ Physical/emotional disability

☐ Medication stabilization

☐ Concerns about child/adolescent (for parent)

☐ Separation from primary caregiver (for child)

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

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4. Referral

☐ Within school (specify) ____________________

☐ Community response agencies

☐ Professional mental health services

☐ Other _________________________________

☐ Substance abuse treatment

☐ Other community services

☐ Medical treatment

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