

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

- | | |
|--|--|
| <input type="checkbox"/> Within project (specify) _____ | <input type="checkbox"/> Substance abuse treatment |
| <input type="checkbox"/> Other disaster agencies | <input type="checkbox"/> Other community services |
| <input type="checkbox"/> Professional mental health services | <input type="checkbox"/> Clergy |
| <input type="checkbox"/> Medical treatment | <input type="checkbox"/> Other: _____ |

5. Was the referral accepted by the individual?

- Yes No

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Psychological First Aid Components Provided

Date: _____ Provider: _____ Location: _____

This session was conducted with (check all that apply):

- Child Adolescent Adult Family Group

Place a checkmark in the box next to each component of Psychological First Aid that you provided in this session.

Contact and Engagement

- Initiated contact in an appropriate manner Asked about immediate needs

Safety and Comfort

- | | |
|---|--|
| <input type="checkbox"/> Took steps to insure immediate physical safety | <input type="checkbox"/> Gave information about the disaster/risks |
| <input type="checkbox"/> Attended to physical comfort | <input type="checkbox"/> Encouraged social engagement |
| <input type="checkbox"/> Attended to a child separated from parents | <input type="checkbox"/> Protected from additional trauma |
| <input type="checkbox"/> Assisted with concern over missing loved one | <input type="checkbox"/> Assisted after death of loved one |
| <input type="checkbox"/> Assisted with acute grief reactions | <input type="checkbox"/> Helped with talking to children about death |
| <input type="checkbox"/> Attended to spiritual issues regarding death | <input type="checkbox"/> Attended to traumatic grief |
| <input type="checkbox"/> Provided information about funeral issues | <input type="checkbox"/> Helped survivors after body identification |
| <input type="checkbox"/> Helped survivors regarding death notification | |
| <input type="checkbox"/> Helped with confirmation of death to child | |

Stabilization

- Helped with stabilization Used grounding technique
 Gathered information for medication referral for stabilization

Information Gathering

- | | |
|---|--|
| <input type="checkbox"/> Nature and severity of disaster experiences | <input type="checkbox"/> Death of a family member or friend |
| <input type="checkbox"/> Concerns about ongoing threat | <input type="checkbox"/> Concerns about safety of loved one(s) |
| <input type="checkbox"/> Physical/mental health illness and medication(s) | <input type="checkbox"/> Disaster-related losses |
| <input type="checkbox"/> Extreme guilt or shame | <input type="checkbox"/> Thoughts of harming self or others |
| <input type="checkbox"/> Availability of social support | <input type="checkbox"/> Prior alcohol or drug use |
| <input type="checkbox"/> History of prior trauma and loss | <input type="checkbox"/> Concerns over developmental impact |
| <input type="checkbox"/> Other: _____ | |

Practical Assistance

- Helped to identify most immediate need(s) Helped to clarify need(s)
 Helped to develop an action plan Helped with action to address the need

Connection with Social Supports

- Facilitated access to primary support persons Discussed support seeking and giving
 Modeled supportive behavior Engaged youth in activities
 Helped problem-solve obtaining/giving social support

Information of Coping

- | | |
|--|---|
| <input type="checkbox"/> Gave basic information about stress reactions | <input type="checkbox"/> Gave basic information on coping |
| <input type="checkbox"/> Taught simple relaxation technique(s) | <input type="checkbox"/> Helped with family coping issues |
| <input type="checkbox"/> Assisted with developmental concerns | <input type="checkbox"/> Assisted with anger management |
| <input type="checkbox"/> Addressed negative emotions (shame/guilt) | <input type="checkbox"/> Helped with sleep problems |
| <input type="checkbox"/> Addressed substance abuse problems | |

Linkage with Collaborative Services

- Provided link to additional services service(s): _____
 Promoted continuity of care _____
 Provided handout(s) _____