

McLaren Northern Michigan
SUICIDE PREVENTION ADULT SAFETY PLAN

PATIENT NAME: _____ **D.O.B.:** _____

As you fill in this form, focus on your own needs and what would be helpful to you in times of crisis. Your healthcare provider may also review with you to discuss ideas. The one thing that is most important to me and worth living for is:

Warning Signs

Signs that a crisis might be developing. What are some thoughts, daydreams, wishes, and so on that signal danger for me?

- _____
- _____
- _____

Internal Coping Strategies

What takes my mind off my problems? Relaxation techniques, physical activity, hobbies, or something else?

- _____
- _____
- _____

People and Social Settings that can distract me

Who can I call on to distract me? Where can I go?

- Name: _____ Phone: _____
- Name: _____ Phone: _____
- Name: _____ Phone: _____

People who can help

Who can I call when I need help? Friends, Family, or someone else?

- Name: _____ Phone: _____
- Name: _____ Phone: _____
- Name: _____ Phone: _____

Professionals or Agencies I can contact during a crisis

Who can I call for help? My doctor, a mental health provider, or a suicide hotline?

- Clinician name: _____ Phone: _____ Pager or emergency # _____
- Clinician name: _____ Phone: _____ Pager or emergency # _____
- Local urgent care services: _____ Phone: _____
- Address: _____
- Suicide prevention lifeline phone: **1-800-273-TALK (8255)**

Internal Coping Strategies

How can I make my environment safer? For example, can I remove guns, medications, and other items?

- _____
- _____

_____ Staff Print Name	_____ Staff Signature	_____ Date	_____ Time
_____ RN Print Name	_____ RN Signature	_____ Date	_____ Time
	_____ Patient Signature	_____ Date	_____ Time

