PATIENT I.D. DATA:
(name, DOC #, birthdate)

Department of Corrections
WASHINGTON STATE

MENTAL HEALTH SAFETY PLAN

DATE	FACILITY	UNIT (optional)

Safety Plan

List recommended actions for patient to take to stay safe (select from the list and/or add your own):

- ☐ See my Primary Therapist, _____, on a regular basis and follow recommendations.
- ☐ Meet with my psychiatric prescriber to discuss medications if appropriate.
- ☐ If prescribed medications, take them as directed.
- ☐ Attend the _____ therapy group so I can learn and apply some new skills that will help me to manage my distress better.
- ☐ List patient specific ideas to personalize the Safety Plan:
- ☐ Additional actions:

What warning signs could you or others be looking for to show you might be thinking of suicide in the future?

What will you do when you recognize these signs?

Who can you notify if you are feeling suicidal? (Be specific)

Housing Considerations (check all that apply)

- ☐ No alternate housing needs at this time
- ☐ Urgent transfer to another facility for MH reasons indicated
- ☐ Urgent referral to Residential Treatment Unit indicated
- ☐ Routine referral to Residential Treatment Unit indicated
- ☐ Other housing considerations:

Housing Unit Supervisor alert needed? ☐ Yes ☐ No

Comments:

Once a Safety Plan is developed and agreed to, the patient signs and dates below:

PATIENT SIGNATURE	DATE
CLINICIAN PRINTED NAME, TITLE, AND SIGNATURE	DATE

All Safety Plans must be reviewed and signed by a Clinical Supervisor:

CLINICAL SUPERVISOR PRINTED/STAMPED NAME, TITLE, AND SIGNATURE	DATE

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.