**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.**

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

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.

__________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________

4. Referral

☐ Within school (specify) ____________________________ ☐ Substance abuse treatment
☐ Community response agencies ☐ Other community services
☐ Professional mental health services ☐ Medical treatment
☐ Other _____________________________________________

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