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.

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

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

- Within project (specify) ____________________________ ☐ Substance abuse treatment
- Other disaster agencies ☐ Other community services
- Professional mental health services ☐ Clergy
- Medical treatment ☐ Other: ______________________________________________

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

☐ Took steps to insure immediate physical safety

☐ Gave information about the disaster/risks

☐ Attended to physical comfort

☐ Encouraged social engagement

☐ Attended to a child separated from parents

☐ Protected from additional trauma

☐ Assisted with concern over missing loved one

☐ Assisted after death of loved one

☐ Assisted with acute grief reactions

☐ Helped with talking to children about death

☐ Attended to spiritual issues regarding death

☐ Attended to traumatic grief

☐ Assisted with concern over missing loved one

☐ Assisted with acute grief reactions

☐ Assisted with concern over missing loved one

☐ Assisted with acute grief reactions

**Stabilization**

☐ Helped with stabilization

☐ Used grounding technique

☐ Gathered information for medication referral for stabilization

**Information Gathering**

☐ Nature and severity of disaster experiences

☐ Death of a family member or friend

☐ Concerns about ongoing threat

☐ Concerns about safety of loved one(s)

☐ Physical/mental health illness and medication(s)

☐ Disaster-related losses

☐ Extreme guilt or shame

☐ Thoughts of harming self or others

☐ Availability of social support

☐ Prior alcohol or drug use

☐ History of prior trauma and loss

☐ Concerns over developmental impact

☐ 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**

☐ Gave basic information about stress reactions

☐ Gave basic information on coping

☐ Taught simple relaxation technique(s)

☐ Helped with family coping issues

☐ Assisted with developmental concerns

☐ Assisted with anger management

☐ Addressed negative emotions (shame/guilt)

☐ Helped with sleep problems

☐ Addressed substance abuse problems

**Linkage with Collaborative Services**

☐ Provided link to additional services service(s):

☐ Promoted continuity of care

☐ Provided handout(s)