

Form # 710 (A) Crisis Intervention and Emergency Services

Clark Quality Care

Name (Last, First, Middle):	Medicaid Number #	Date
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<input type="checkbox"/> Crisis <input type="checkbox"/> Illness <input type="checkbox"/> Injury	Date of Illness/Injury	Time of Illness/Injury	Temp	BP	HR	Resp	Take Temperature, Blood Pressure, HR or Resp. if pertinent to condition.
Description of Nature and Circumstances Surrounding the Crisis or Emergency:							
Description of Precipitating Factors:							

Intervention or Treatment Provided:			
<input type="checkbox"/> Gave Prescribed Medication (See MAR)	<input type="checkbox"/> Illness Complaint Resolved after _____ minutes.		
<input type="checkbox"/> Called 911 For Ambulance	Time of Call:	Time Ambulance Arrived:	<input type="checkbox"/> Transported to Hospital <input type="checkbox"/> Treated at Site
<input type="checkbox"/> Went to the Emergency Room:		Time of Arrival to Emergency Room:	
<input type="checkbox"/> Applied First Aid (See Comments Below)			
Employees or Contractors Responding to or Consulted During Crisis or Emergency:			
<input type="checkbox"/> Called Physician	Time of Call:		Describe all details of any calls to professionals including the name and the instructions given below.
<input type="checkbox"/> Physician Visit	Date/	Time of Visit:	
<input type="checkbox"/> Called CEO	Date/	Time of Call:	
<input type="checkbox"/> Went to Emergency Room	Time Arrived at Hospital /		
<input type="checkbox"/> Called Poison Control	Date/	Time of Call:	
<input type="checkbox"/> Called Emergency Contact	Date/	Time of Call:	
<input type="checkbox"/> Employee (s) / Contractor (s) Involved:			
<input type="checkbox"/> Crisis Evaluation Done:	Crisis Evaluator:	Date Contacted:	Time Contacted:

Outcome:			
Signature:	Print Name:	Date:	<input type="checkbox"/> Form Placed in Office File