Mental Health Safety Plan

Name: _____ DoB: _____ dd / mm / yyyy

Mental Health Practitioner: _____ Contact: _____

WARNING SIGNS

1:

2:

3:

MY COPING SKILLS

1:

2:

3:

SUPPORT PEOPLE I CAN ASK FOR HELP

1:

2:

3:

EMERGENCY CONTACTS

1: _____ Phone: _____

2: _____ Phone: _____

3: _____ Phone: _____

4: _____ Phone: _____

5: _____ Phone: _____

6: _____ Phone: _____

HOW CAN I MAKE MY ENVIRONMENT SAFE?

1:

2:

3:

I will contact my support people when...

I will contact my mental health professional when...

I will contact emergency services when...

Patient Signature:

Mental Health Practitioner Signature: