NEBRASKA
Good Life. Great Mission.

My Child is Having a Mental Health Crisis – What Now?

Being in a mental health crisis with a family member is very stressful, time consuming, and not widely understood. It's difficult to find the right support, guidance, and comfort. Your journey and family are unique to you!

You are doing your best and we want to give you a tool to make some parts of this journey a little easier.

This packet was designed by families who have visited the emergency room, clinic, or a specialist's office multiple times to keep their children safe. We know first-hand that in a crisis, it is hard to remember dates, names, and events. The information that you provide should paint a clearer picture of your child and give their medical team a framework to approach their patient.

This packet will help you organize a record of important information that may be requested during a variety of appointments including ER visits, medical appointments, school meetings, etc. This packet provides guided forms to capture information regarding your child's physical and mental health, family history, and any out-of-home placements. This packet is meant to be used by parent(s), guardian(s), or designated caregiver(s) on an ongoing basis so that it has accurate and appropriate information when a crisis occurs.

Need immediate help?

- Worried your child is having a psychiatric emergency? Learn more here
- Call, text, or chat with 988 for suicide and crisis support.

988 SUICIDE & CRISIS LIFELINE

Connect and learn about family support resources:

- Access resources near you with the Nebraska Network of Care: https://portal.networkofcare.org/NebraskaBehavioralHealth
- Confused by health care terms? Browse thousands of terms in plain, clear language here: https://justplainclear.com/en. This page is available in 5 languages.
- Learn more about mental health topics

Keep this packet updated and with you (we recommend you keep it on a reliable personal device such as a laptop, tablet or smartphone AND on paper such as in your glovebox or purse) so that you have easy access to information that could be required of you at new appointments or in the emergency room.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services
Emergency Information/Family Resource Packet

History of the Child	
Legal Name:	Preferred Name:
Date of Birth:	Gender: ☐ Female ☐ Male
Home Address(es):	
Parent Names:	Foster Parent or Caregiver Names:
Guardian:	Language Spoken at Home: ☐ English ☐ Spanish ☐ Other:_____
In a few words, describe the most important things you would like the medical team to know (specific fears, triggers, things that might help make them feel more comfortable, etc.):	
List some of your child's strengths:	

Medical History of the Child

Mental health diagnoses or concerns:
Medical diagnoses or concerns:
List substances used/misused by child (like pills, alcohol, etc):
Medication compliance (check all that apply): ☐ Independent ☐ Supervision ☐ Refusal ☐ Inconsistent

About My Child

Family History

The child lives with (select all that apply): ☐ Mother ☐ Father ☐ Siblings ☐ Grandparents ☐ Other

Number of people living in the house:

Parents/Guardian marital status:
☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Co-Parents

Is the child in the foster care system: ☐ Yes ☐ No

Juvenile justice system: ☐ Yes ☐ No

How long has the child lived in their current community?

Development

Is the child developing appropriately compared to others their age?
☐ On Track ☐ A Little Delayed ☐ Advanced ☐ Significantly Behind ☐ I'm Not Sure

Describe any relevant birth history and/or developmental delays of the child: ☐ Unknown

My child struggles with:
☐ Sensory Processing ☐ Sensory Modulation ☐ Communication ☐ Social Skills
☐ Emotional Modulation ☐ Cognitive Ability ☐ Motor Skills ☐ Focusing

Optional description:

My Child's Providers

List your child's providers:
Consider listing providers like your child's primary care provider, specialist, mental health therapist, psychologist, psychiatrist, IEP case manager or others.

Provider Name	Type of Care Provided	Location/Facility Name	Phone
Dr. Joe Brown	*Psychiatrist-prescribes meds*	*Bryan Health, Lexington*	*308-324-1111*

Evaluations and Assessments

List any assessments or evaluations that have been completed for your child:
Include MRI/genetic/GeneSight or other relevant testing that may be considered "medical"

Evaluations/Assessments	Date	Location/Provider

Diagnoses

List any diagnoses that have been given to your child (include removed or changed or challenged diagnoses):
Look at discharge paperwork or treatment plans given by providers for this information as mental health diagnoses can be described differently depending on the situation.

Diagnosis	Date	Location/Provider	Changed?

List of Physical Symptoms

Please select how often your child has experienced these symptoms **within the past 6 months:**

My child has...	Never	Rarely	Sometimes	Often	Always
Had headaches or migraines					
Had ear infections or pain					
Had a fever of over 100.4˚ F					
Been dizzy or has lost their balance					
Tires easily while doing their usual activities					
Oversleeps, I have trouble waking them					
Is restless and has insomnia					
Is groggy, feels drained, and has low energy					
Is hyperactive, filled with energy, and hard to calm down					
Gained weight					
Lost weight					
Developed vision problems					
Developed hearing problems					
Had multiple ear infections					
Developed unexpected rashes, markings, bumps, etc.					

Potential Traumatic Experiences

Select any potentially traumatic experiences your child has faced:

	Parent's divorce		Has been a victim of physical abuse
	Has been in a car accident		Has been removed from their home
	Has been in a fire incident		Has been a victim of gun violence
	Has witnessed the death of an family member Describe:		Has been a victim of sexual abuse
	Death of a close friend		Has witnessed sexual abuse
	Has been a victim of bullying or emotional abuse		Has witnessed an immediate family member be incarcerated or deported
	Has been in a natural disaster Describe:		Other Describe:
	Has witnessed physical abuse		

Triggers/Response to Trauma

Select any that apply:

	Has reoccurring memories of the incident		Has panic attacks
	Has nightmares of incident		Has depression
	Feels upset when thinking or talking about the incident		Has partial memory of the incident/attempts to repress memory
	Isolates themselves/sudden disinterest in hobbies		Has developed insomnia
	Avoids people, events, or locations that may remind the child of the incident		Feels irritable or quick to anger
	Hides when loud sounds are made		Has trouble concentrating
	Panics when a comfort item is lost		Increase in anxiety
	Seeks attention by misbehaving		Other Describe:

Significant Event Timeline

Use this space to document events to create a full picture of your child's journey. This might include out of home placements (foster care, group home, psychiatric hospital), suspensions, ER visits, contact with law enforcement (arrests, probation, juvenile detention), graduation from programs, starting new programs, discontinuing or changing medication treatments… anything you think might be helpful for a provider to make the best, informed decision for your family member.

Note outcome or follow-up recommended.

Date	Event