



## Patient Safety Plan/Agreement

Things I can do to distract myself from my problems or when I feel down (physical activities, relaxation techniques, apps, social settings I can go to, etc):

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People who care about me that I can call or go to when I feel overwhelmed (include at least one adult):

Name	Relationship	Phone Number

### **Professionals or agencies I can contact during a crisis:**

**Dominion Psychiatric Hospital Intake Line** Phone 844-710-6165

**Fairfax County Emergency Services-** assessment for all ages and Mobile Crisis Phone 703-573-5679

**Inova IPAC 24/7 Adult assessment (18+)** Phone 703-289-7560

**Loudoun County Crisis Intervention** Phone 703-777-0320

**Prince William County Crisis Manassas: 703-792-7800, Woodbridge: 703-792-4900**

### **Any Emergency Room**

(Inova Fairfax Children's Hospital and Children's National Medical Center in DC, preferred)

**Capital Area Pediatrics provider** On-call providers are here 24/7 who can help you determine next steps. 703-359-5100

**National Suicide Prevention Lifeline:** Text or Call 988 or to Chat go to: [988lifeline.org/chat](https://988lifeline.org/chat)

**Trevor Project Lifeline:** For LGBTQ-specific support, **Text START to 678678**



**I will do one or more of the following items instead of hurting myself:**

1. I can talk to my therapist, a family member, or other trusted adult about my feelings.
2. I can do or tell myself some of the things I wrote down on the first page.
3. I can call one of the hotline numbers listed on page 1 or I can call 911
4. I can ask someone to take me to the hospital. If no one is around, I can call 911. The hospital is a safe place where I can get help and can be safe from hurting myself.

By signing this safety plan/agreement in the presence of a clinician, I agree to take positive actions whenever I feel like hurting myself. I will not hurt myself or try to kill myself. I will be near people who can help me or will be able to make a phone call if I need to contact people who can help me.

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Patient Signature

\_\_\_\_\_  
Date

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Witness/Clinician

\_\_\_\_\_  
Date