CLERKING SHEET
PSYCOLOGICAL FIRST AID

DATE :
LOCATION :

PROVIDER NAME : KKM / NON KKM

1. **SURVIVOR PARTICULAR/HEALTH STAFF PARTICULAR**

NAME :
RACE :
ID NO : **AGE** :
ADDRESS :
PHONE NO :
CO MORBID :

2. **SESSION**

INDIVIDUAL ☐ GROUP ☐

3. **PROBLEM IDENTIFIED**

ACUTE STRESS REACTION	☐	ANXIETY	☐
ACUTE GRIEF REACTION	☐	POST TRAUMATIC STRESS DISORDER	☐
ANGER	☐	IRRITABILITY	☐
HYPERVENTILATION	☐	OTHERS (please specify)	☐

4. **BRIEF INTERVENTION**

DEEP BREATHING EXERCISE	☐	ART ACTIVITIES	☐
RELAXATION TECQNIQUE	☐	OTHERS (please specify)	☐
GROUP SESSION	☐		☐

5. **PLAN**

REFER TO OTHER AGENCIES	☐	REFER TO HOSPITAL	☐
DISCHARGE WITH REASSURANCE	☐	REFER TO COUNSELLOR	☐
REFER TO HEALTH CLINIC	☐	ADMIT	☐

ATTENDING PROVIDER:

NAME : **DATE:**
SIGNATURE :