HELP REQUEST FORM
Forma Para Pedir Ayuda

Facility: _____

Please fill in the following information as clearly as possible.
Por favor de completar la informacion siguiente lo mas claro possible.

Your Name: _____ **Date of Birth:** _____
Nombre ***Fecha de Nacimiento***

Today's Date: _____ ☐ Male ☐ Female **Unit / Cottage:** _____
Fecha de Hoy *Hombre* *Mujer* ***Unidad/Cabaňa***

Request for: ☐ Medical Care ☐ Mental Health Care ☐ Counselor ☐ Dental Care
Pedir Ayuda Para *Cuidado Medico* *Cuidado de Salud Mental* Consejero *Cuidado Dental*

Describe your problem: ***Describa su problema:***

_____
_____
_____
_____

DO NOT WRITE BELOW THIS LINE
NO ESCRIBA DEBAJO DE ESTA LINEA

SORTED/TRIAGED BY: Name: _____ Date / Time: *(stamp)* _____
(stamp or signature/title)

(indicate assigned service provider)

☐ RN ☐ LPN ☐ NP ☐ PA ☐ MD ☐ Dental ☐ Other: _____
☐ QMHP ☐ Counselor ☐ Psychologist ☐ Psychiatrist

DISPOSITION ☐ See Mental Health Assessment ☐ See JTS Case Note

Subjective: _____
_____
_____
_____

Objective: _____
_____
_____
_____
_____

Assessment: _____
_____
_____

Plan: **DJJ Nursing Protocol #:** _____ _____
_____
_____
_____
_____
_____

Signature / Title: _____ **Date:** _____ **Time:** _____