

# Critical Incident Stress Debriefing Coordination Form

Coordinator: \_\_\_\_\_

Date for Debriefing: \_\_\_\_\_

Time for Debriefing: \_\_\_\_\_

Location for Debriefing: \_\_\_\_\_

## Attending CISM Members

Mental Health (Lead): \_\_\_\_\_

Mental Health (Assist): \_\_\_\_\_

Peer Support: \_\_\_\_\_

Peer Support: \_\_\_\_\_

## Debriefing Outcome

Number of Attendees: \_\_\_\_\_

Follow Up Needed? \_\_\_\_\_ Yes \_\_\_\_\_ No

When: \_\_\_\_\_

Where: \_\_\_\_\_

Referrals? \_\_\_\_\_ Yes \_\_\_\_\_ No

Themes/Comments:

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Person Completing Form (Signature) \_\_\_\_\_