

SOUTHERN ILLINOIS UNIVERSITY
EDWARDSVILLE
CONCERNED FOR OTHERS REPORT

YOUR NAME: _____ **Contact #:** _____ **Today's Date:** _____

NAME OF PERSON YOU ARE CONCERNED ABOUT: _____

If a student: SSN or SIUE student #: _____

NOTABLE OBSERVATIONS OF PERSON'S BEHAVIOR OR APPEARANCE:

Please note if the date of occurrence is different from the date of this report.

- | | | |
|---|--|---|
| <input type="checkbox"/> Poor Grooming | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Hostile |
| <input type="checkbox"/> Tearful/Crying | <input type="checkbox"/> Inappropriate Touching | <input type="checkbox"/> Fidgety |
| <input type="checkbox"/> Social Isolation | <input type="checkbox"/> Intimidating to Others | <input type="checkbox"/> Threatening |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Frequent Absences | <input type="checkbox"/> Argumentative |
| <input type="checkbox"/> Suspicious | <input type="checkbox"/> Poor Performance | <input type="checkbox"/> Stalking |
| <input type="checkbox"/> Slurring Words | <input type="checkbox"/> Abusive Language | <input type="checkbox"/> Noncompliant |
| <input type="checkbox"/> Avoiding Others | <input type="checkbox"/> Seems to be Seeing or
Hearing Things | <input type="checkbox"/> Burns or Cuts |
| <input type="checkbox"/> Odor | <input type="checkbox"/> Frequent Injuries | <input type="checkbox"/> Doesn't Show
Emotions |
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Extremely Thin | <input type="checkbox"/> Other |
| <input type="checkbox"/> Poor Hygiene | | |

Issues reported to you by the person:

- | | | |
|--|--|---|
| <input type="checkbox"/> Suicide Plan
(please note when,
where, and how below) | <input type="checkbox"/> Child Abuse/Neglect | <input type="checkbox"/> Legal / Disciplinary
Problems |
| <input type="checkbox"/> Suicide Preparation | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Academic Concerns |
| <input type="checkbox"/> Suicide Rehearsal | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Shame / Guilt |
| <input type="checkbox"/> History of Suicidality | <input type="checkbox"/> Significant Loss | <input type="checkbox"/> Sexual Assault / Abuse |
| <input type="checkbox"/> Homicidal Plan | <input type="checkbox"/> Interpersonal Isolation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Assaultive Plan | <input type="checkbox"/> Relationship Problems | |
| | <input type="checkbox"/> Health Problems | |

Other Significant Information:

Any Previous Incidents?

Any action already taken?

Is there a follow plan?

REPORTED TO:

- | | | | | |
|--|------------------|--------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Dean of Students | Date/Time: _____ | <input type="checkbox"/> Email | <input type="checkbox"/> Telephone | <input type="checkbox"/> In Person |
| <input type="checkbox"/> Campus Police | Date/Time: _____ | <input type="checkbox"/> Email | <input type="checkbox"/> Telephone | <input type="checkbox"/> In Person |
| <input type="checkbox"/> Counseling Services | Date/Time: _____ | <input type="checkbox"/> Email | <input type="checkbox"/> Telephone | <input type="checkbox"/> In Person |
| <input type="checkbox"/> Housing Director | Date/Time: _____ | <input type="checkbox"/> Email | <input type="checkbox"/> Telephone | <input type="checkbox"/> In Person |
| <input type="checkbox"/> Department Head | Date/Time: _____ | <input type="checkbox"/> Email | <input type="checkbox"/> Telephone | <input type="checkbox"/> In Person |
| <input type="checkbox"/> Human Resources | Date/Time: _____ | <input type="checkbox"/> Email | <input type="checkbox"/> Telephone | <input type="checkbox"/> In Person |

Completed form was submitted to (check one):

____ Dean of Students, Box 1058, or faxed to 618-650-3388 on: _____.

____ Counseling Services, Box 1154 or faxed to 618-650-2217 on: _____.

____ Human Resources, Box 1040, or faxed to 618-6502696 on: _____.