

**MENTAL HEALTH - CRISIS INTERVENTION (CIT) REPORT**

CHICAGO POLICE DEPARTMENT

Date/Time Assigned

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Address of Incident		Location Code	Beat of Occurrence	Assigned by <input type="checkbox"/> OEMC <input type="checkbox"/> Supervisor <input type="checkbox"/> On-View	
Event No.	RD No. (If applicable)		CB No. (If applicable)	IR No. (If applicable)	
Previous Interaction <input type="checkbox"/> Yes <input type="checkbox"/> No	If known, list no. of times		Was Mental Health component indicated before arrival? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Subject Information**

Name			Address		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age	Race <input type="checkbox"/> 1-Black <input type="checkbox"/> 2-White <input type="checkbox"/> 3-Black-Hispanic <input type="checkbox"/> 7-Other <input type="checkbox"/> 4-White-Hispanic <input type="checkbox"/> 5-Amer. Ind/Alask. <input type="checkbox"/> 6-Asian/Pacific Islander		
Living Arrangements <input type="checkbox"/> Homeless <input type="checkbox"/> Family <input type="checkbox"/> Independent <input type="checkbox"/> Assisted Living <input type="checkbox"/> Unknown					

**Hospitalization/Treatment**

Prior mental health hospitalization	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Prior mental health treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Current mental health treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If known, list Doctor's Name and Agency			

Currently taking medication for mental illness  Yes  No  Unknown  
(If known, indicate name and last time the medication(s) were taken)

Did you observe any of the following (Check as many as apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Nothing unusual observed           | <input type="checkbox"/> Severe, depressed mood   |
| <input type="checkbox"/> Absurd, illogical thinking/talking | <input type="checkbox"/> Suicidal talk  |
| <input type="checkbox"/> Abnormal behavior/appearance       | <input type="checkbox"/> Suicidal gesture(s)  |
| <input type="checkbox"/> Hearing voices/hallucinating       | <input type="checkbox"/> Signs of alcohol/illegal drug use  |
| <input type="checkbox"/> Anxious/excited                    | <input type="checkbox"/> Possible developmental disability  |
| <input type="checkbox"/> Paranoid or suspiciousness         | <input type="checkbox"/> Aggressive/threatening behavior or speech  |
| <input type="checkbox"/> Violent behavior                   | <input type="checkbox"/> Weapons, if checked <input type="checkbox"/> Displayed <input type="checkbox"/> Used |

**Member Actions**

<input type="checkbox"/> Contact only: Card No. _____	Methods Used (Check all that apply)
<input type="checkbox"/> Transported to _____	<input type="checkbox"/> Verbal
Type of facility <input type="checkbox"/> Hospital <input type="checkbox"/> Substance Abuse Facility	<input type="checkbox"/> Physical restraint
<input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Community Mental Health Facility	<input type="checkbox"/> OC Chemical Weapon
<input type="checkbox"/> Governmental Agency <input type="checkbox"/> Home <input type="checkbox"/> Other _____	<input type="checkbox"/> Canine
<input type="checkbox"/> Hospitalization <input type="checkbox"/> Yes <input type="checkbox"/> No Specify _____	<input type="checkbox"/> Impact Weapon
If yes, <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary	<input type="checkbox"/> Taser
Petition completed by member <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Firearm
Reason for Hospitalization	<input type="checkbox"/> Other _____
<input type="checkbox"/> Harm to self <input type="checkbox"/> Harm to others <input type="checkbox"/> Basic needs not met	Specify _____

**CIT Officers (This section to be completed by CIT Officers only)**

Rate highest level of subject <input type="checkbox"/> 1- Anxiety <input type="checkbox"/> 2- Anger <input type="checkbox"/> 3-Hostility <input type="checkbox"/> 4-Violence	
Subject's actions <input type="checkbox"/> Cooperative <input type="checkbox"/> Passive Resister <input type="checkbox"/> Active Resister <input type="checkbox"/> Assailant	
Were CIT Training Techniques Used? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were the techniques successful? <input type="checkbox"/> Yes <input type="checkbox"/> No
Member's Name <input type="checkbox"/> CIT Star No. Beat No.	Member's Name <input type="checkbox"/> CIT Star No. Beat No.

CIT Supervisor's Approval	Date/Time Completed	Reports Attached <input type="checkbox"/> Case Report <input type="checkbox"/> Arrest Report <input type="checkbox"/> TRR <input type="checkbox"/> Other
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**CPD-15.520 (Rev. 2/13)** Please return this report to the CIT Program, Unit 441. Fax # (312) 745 - 6980.  
Use reverse side for any additional information and attach all relevant reports.