PERSONAL CRISIS PLAN

What I'm like when I'm feeling well.

Signs I Need My Supporters

If I have several of the following signs and/or symptoms, call my supporters, named on the next page.

Information on Medications / Supplements / Health Care Information

Physician _____ Psychiatrist _____

Other Health Care Providers:

Pharmacy _____ Pharmacist _____

Allergies

Insurance Information _____

Medication / Supplement / Health Care Preparation I am currently using
Dosage _____Purpose_____

Medication / Supplement / Health Care Preparation I am currently using
Dosage _____Purpose

Treatments and Complementary Therapies that work well for me

Treatment/Complementary Therapy

_____

When and how to use this treatment/complementary therapy

_____

Help from Others

Please do the following things that would help reduce my uncomfortable feelings, make me more comfortable, and keep me safe.

_____
_____
_____

I need (name the person) _____ to (task) Phone number:

_____

I need (name the person) _____ to (task) Phone number:

_____

Do not do the following. It won't help and it may even make things worse.

_____
_____
_____
_____
_____

Inactivating the Plan

The following signs or actions indicate that my supporters no longer need to use this plan.

_____
_____
_____
_____

I developed this plan on (date) _____ with the help of

_____

Any plan with a more recent date supersedes this one.

Signed _____Date _____

Witness _____ Date _____

Adapted from: