My Care Plan

MY MEDICAL PROVIDERS

My Doctor or PCP:
#:

My Therapist:
#:

My Psychiatrist:
#:

My Pharmacy:
#:

MY MEDICATIONS, VITAMINS, & SUBSTANCES

Name:
Dosage:
Date Started:

Name:
Dosage:
Date Started:

Name:
Dosage:
Date Started:

Name:
Dosage:
Date Started:

Allergies:

My Care Plan

MY SUPPORT SYSTEMS

Name:
#:
Can we contact them on your behalf?
Y N
Can we say who we are?
Y N

Name:
#:
Can we contact them on your behalf?
Y N
Can we say who we are?
Y N

Name:
#:
Can we contact them on your behalf?
Y N
Can we say who we are?
Y N

Name:
#:
Can we contact them on your behalf?
Y N
Can we say who we are?
Y N

MY TREATMENT PREFERENCES

If necessary, I prefer this treatment facility:

I want to avoid (people, places, things):

My Care Plan

SYSTEMS OF CARE

SF Mobile Crisis: 415-970-4000 *Mon-Fri 8:30am-11pm Sat 12-8pm

National Suicide Hotline: 1-800-273-8255

Trevor Project: 1-866-488-7386

Trevor Project Text Line: 678-678

Trans Lifeline: 1-877-565-8860

Nearest Emergency Room/ Urgent Care:

SIGNS TO LOOK OUT FOR

I am well when:	I am unwell when:
-	-
-	-
-	-

SFLGBTCENTER

My Care Plan

WELLNESS TOOLS

Things that make me feel better:

-
-
-

Things that make me feel worse:

-
-
-

AFFIRMATIONS FOR SELF

-
-
-

My Care Plan

I,_____ created this plan. Any plan with a more recent date replaces this one. (For your continued health and safety, we recommended that you update your care plan once a year and share it with your medical providers.)

x_____

Date Signed: