My Care Plan

(the following is an example of a filled out care plan to provide you with guidance and support if you choose to fill out one for yourself)

MY MEDICAL PROVIDERS

My Doctor or PCP: Dr. A
#: (415)123-4567

My Therapist: Dr. C
#: (415)123-4567

My Psychiatrist: Dr. B
#: (415)123-4567

My Pharmacy: Walgreens on D St.
#: (415)123-4567

MY MEDICATIONS, VITAMINS, & SUBSTANCES

Name: A
Dosage: 11g 2 times a day
Date started: Jan 2021

Name: C
Dosage: 33g 1 time a day
Date started: May 2021

Name: B
Dosage: 22g 3 times a day
Date started: Jan 2021

Name: D
Dosage: 44g when needed
Date started: October 2021

Allergies: E, F, G

My Care Plan

MY SUPPORT SYSTEMS

Name: A
#: (415)123-4567
Can we contact them on your behalf?
(Y) N
Can we say who we are?
Y (N)

Name: B
#: (415)123-4567
Can we contact them on your behalf?
(Y) N
Can we say who we are?
(Y) N

Name: C
#: (415)123-4567
Can we contact them on your behalf?
(Y) N
Can we say who we are?
(Y) N

Name: D
#: (415)123-4567
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: (name & address)

I want to avoid (people, places, things): encounters with... this area... substances like...

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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: (search and insert here)

SIGNS TO LOOK OUT FOR

I am well when:

- I am eating
- I am moving around and socializing
- I am well rested

I am unwell when:

- I don't feel like eating
- I can't get out of bed
- I haven't slept enough

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My Care Plan

WELLNESS TOOLS

Things that make me feel better:

- Water, snacks
- Space and then a listening ear
- Validation & affirmation

Things that make me feel worse:

- Large crowds
- Loud noises
- Too many questions

AFFIRMATIONS FOR SELF

- This too shall pass
- My chosen family cares for me
- I am beautifully me

My Care Plan

I,__(print name)__ 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__(signature)__

Date Signed: xx/xx/xx