MY MEDICAL PROVIDERS

My Doctor or PCP: Dr. A

#: (415)123-4567

My Psychiatrist: Dr. B

#: (415)123-4567

My Therapist: Dr. C

#: (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: B

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

Name: C

Dosage: 33g I time a day Date started: May 2021

Name: D

Dosage: 44g when needed Date started: October 2021

Allergies: E, F, G





(KEY EDITION)

MY SUPPORT SYSTEMS

Name: A

#: (415)123-4567

Can we contact them on your behalf (Y)

Can we say who we are?

Name: B

#: (415)123-4567

Can we contact them on your behalf ? Y)N

Can we say who we are PYN

Name: C

#: (415)123-4567

Can we contact them on your behalf! (Y)

Can we say who we are YN

Name: D

#: (415)123-4567

Can we contact them on your behalf? YN

Can we say who we are? YN

SYSTEMS OF CARE

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

Național 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)

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 ...







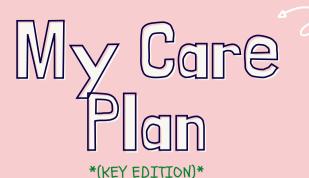
SIGNS TO LOOK OUT FOR

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



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

Brought to you by the SF LGBT Center

SFLGB1 CENTER

AFFIRMATIONS FOR SELF

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

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

x_(signature)_ Date Signed: xx/xx/xx

