My Care Plan

SFLGBT CENTER

MY MEDICAL PROVIDERS

My Doctor or PCP:

#:

My Psychiatrist:

#:

My Therapist:

#:

My Pharmacy:

#:

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 MEDICATIONS, VITAMINS, & SUBSTANCES

Name:
Dosage:
Date started:

Name:
Dosage:
Date started:

Name:
Dosage:
Date started:

Name:
Dosage:
Date started:

Allergies:

SYSTEMS OF CARE

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

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:

MY TREATMENT PREFERENCES

If necessary, I prefer this treatment facility:

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

My Care Plan

SFLGBT CENTER

SIGNS TO LOOK OUT FOR

I am well when:

-

-

-

I am unwell when:

-

-

-

-

WELLNESS TOOLS

Things that make me feel better:

-

-

-

Things that make me feel worse:

-

-

-

-

AFFIRMATIONS FOR SELF

-

-

-

I,_____

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_____

Date Signed: ___/___/___

Last revised 2/2022