NJ Connect for Recovery

Family Education Workshop

Treatment or Crisis Plan

www.mhanj.org

800-367-8850

Hospital or other Treatment Facilities

If I need hospitalization or treatment in a treatment facility, I prefer the following facilities, in order of preference:

Name Contact Person Phone Number

____

I prefer this facility because

____

Name Contact Person Phone Number

____

I prefer this facility because

____

Name Contact Person Phone Number

____

I prefer this facility because

____

Avoid using the following hospitals or treatment facilities:

Name Reason to avoid using

____

____

Insurance Information____

People to Take Over

I would like the following people to take over for me when the symptoms or behaviors listed on the previous page become obvious.

Person’s Name In order of preference	Connection, role, or relationship to me	Phone Number

If there are disputes between my supporters, the following is how I would like the situations handled:____
____
____.

People I Don’t Want to Involved

I would like for the following health care providers, family members, or friends to **NOT BE INVOLVED IN ANY WAY** in my care of treatment.

Person’s Name	Connection, role, or relationship to me	Reason for no involvement

Treatments

These treatments may help **reduce** my symptoms.

Treatments That May Help Me	When These Treatments Should Be Used

These treatments I want to **Avoid.**

Treatments to Avoid	Why These Treatments Should be Avoided

Things that Wouldn't Help

These are things that others **might** do, or have done in the past, that would **NOT** help. They might even worsen my symptoms.

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

These are the medications that I am **currently** taking:

Name of Medication	Dosage	What I Take This Medication for

These are the medications that I would **prefer** to take if medications or additional medications become necessary.

Name of Medications	Dosage	What I Take This Medication for

These medications would be **acceptable** to me if medications became necessary.

Name of Medications	Dosage	What I Take This Medication For

These are the medications that **must be avoided:**

Name of Medications	Dosage	Why I Want to Avoid This Medication

Staying in the Community

This is my plan so that I can stay at home or in the community and still get the care that I need.

Service or Help That I Desire	By Whom	Other Details

These are the facilities that I prefer to be treated or hospitalized at if that becomes necessary.

Name of Facility	Locations	Other Details

These are the treatment facilities that I want to **avoid.**

Name of Facility	Locations	Other Details

Treatment/ Crisis: Post Recovery Support List

I would like the following people to support me if possible during this post crisis time:

Name	Phone Number	What I need them to do:

If I am being discharged from a treatment facility, do I have a place to go that is safe & comfortable?

☐ Yes ☐ No

If not, these are the thing **I need to do** to insure that I have a safe & comfortable place to go: ____

____
____
____

If I have been hospitalized, my first few hours at home are very important. Will I **feel safe and be safe** at home?

☐ Yes ☐ No

If my answer is no, this is what I **need to do** to insure that I will feel and be safe at home:

____
____

I would like____________________________or______________________________

to take me home.

I would like____________________________or______________________________

to stay with me.

When I get home, I would like to ____

or____

If the following things were in place, it would **ease my return** home:____

____

____

These are the things I must take care of **as soon as I can**:

____

____

____

These are the things **I can ask someone else to do** for me:___________________

____

____

____

These are the things that **can wait** until I feel better: _________________________

____

____

____

These are the things I **need** to do for myself every day while I am recovering from a crisis: ____

____

____

____

These are the things I **might** need to do every day while I am recovering from this crisis: ____

____

____

These are the things and people I need to avoid while I am recovering from crisis:

____

____

____

These are signs that I may be beginning to feel worse (examples include anxiety, excessive worry, overeating, sleep disturbances, etc.):_______________________

____

____

____

These are the wellness tools I will use if I am starting to feel worse (put a star beside those that you must do, the others are choices):______________________

____

____

____

Preventive Actions:

These are the things I need to do to prevent further repercussions from this crisis-and when I will do these things:

Things I need to do	When I will do these things

These are people I would like to share my discharge plan with:______________

____

____

Medications/Supplements/Health Care Preparations

Physician____________________ Psychiatrist______________________

Other Health Care Providers

____

____

Pharmacy____________________ Pharmacist_______________________

Allergies____

____

Medication/Supplement/Health Care Preparation I am currently using

Dosage____

Purpose____

Medication/Supplement/Health Care Preparation I am currently using

Dosage____

Purpose____

** Medications/Supplements/Health Care Preparations to avoid Why?

____

____

____

take special note

Other comments about medication, supplements, or health care preparations:____

____

____

____

Treatments and Complementary Therapies

Treatment/Complementary Therapy

____

When and how to use this treatment/complementary therapy

____

____

Treatment/Complementary Therapy

____

When and how to use this treatment/complementary therapy

____
____

Treatment/Complementary Therapy

____

When and how to use this treatment/complementary therapy

____
____

Home Care/ Community Care/ Respite Center

If possible, follow the following care plan:

____
____
____