

MY RECOVERY PLAN

CRISIS PLAN

Adopted from the Substance Abuse and Mental Health Services Administration (SAMHSA) Action Planning for Prevention and Recovery manual.

<https://www.veterantraining.va.gov/apps/recovery/index.html>

Part 1: Feeling well

Write what you are like when you are feeling well. This section is copied from your Feeling Well Daily Plan. This important information can help educate people who might be trying to help you — whether that person knows you well or not at all.

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Part 2: Symptoms / Issues

Describe symptoms that would indicate to others that they need to take over responsibility for your care and make decisions on your behalf.

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Part 3: Medications

List the medications you are currently using, the dosage, and the times taken.

Current Medications	Dose	Times Taken

If Additional Medications Become Necessary:

Preferred Medications

Medications to Avoid:

Part 4: Supporters

List the people (such as family members and friends) who you would like to take over for you when the symptoms you listed in the previous section arise. Before listing people in this part of your plan, talk with them about what you would like from them and make sure they understand and agree to be in the crisis plan.

Name	Cell Phone Number	Home Phone Number	Email Address

Part 5: What You Need From Supporters

Describe what your supporters can do for you that will help you feel better.

Part 6: Special Help You May Need From Supporters

Describe a plan for your care to help keep your life on track.

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Part 7: Health Care Providers

Name your health care providers, along with their contact information.

Health Care Provider	Phone Number	Clinic/Hospital	Address	Email
My Primary Care Provider				
My Peer Specialist				
My Psychologist				
My Psychiatrist				
My Social Worker				
My Specialist				
My Pharmacy				
Other				
Other				
Other				

Part 8: Treatments

Preferred Treatments:

List the treatments you are currently undergoing; treatments you prefer if additional treatments became necessary; and, treatments that would be acceptable to you if treatments were deemed necessary by your support team.

Treatments to Avoid:

List the treatments that must be avoided and why. The reason may be as simple as “this treatment has or has not worked in the past,” or you may have some concerns about the safety of this treatment. Maybe you just don’t like the way a particular treatment makes you feel.

Part 9: Facilities/Providers

Preferred Facilities/Providers:

List the treatment facilities you would like to use if family members and friends cannot provide you with care, or if your condition requires hospital care.

Facility/Provider	Phone Number	Address
VA Medical Facility (Hospital)		
VA Clinic		
Non-VA Hospital		
Non-VA Clinic		
Provider		
Provider		
Provider		
Provider		
Other:		
Other:		
Other:		

Facilities/Providers to Avoid:

Describe the treatment facilities you would like to avoid if family members and friends cannot provide you with care, or if your condition requires hospital care.

Facility/Provider	Phone Number	Address
VA Medical Facility (Hospital)		
VA Clinic		
Non-VA Hospital		
Non-VA Clinic		
Provider		
Provider		
Provider		
Provider		
Other:		
Other:		
Other:		