Crisis Planning

Part 1 – *What I am like when I am feeling well*

Describe yourself when you are feeling well.

Part 2 – *Symptoms*

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

Part 3 – *Supporters*

List those people you want to take over for you when the symptoms you listed above are obvious. They can be family members, friends, or health care professionals. Have at least five people on your list of supporters. You may want to name some people for certain tasks like taking care of the children or paying bills and others for tasks like staying with you and taking you to health care appointments.

*Name:*_____ *Connection/Role:* _____
*Phone Number:*_____

Name: _____*Connection/Role:* _____
Phone Number: _____

*Name:*_____ *Connection/Role:* _____
*Phone Number:*_____

Name: _____*Connection/Role:* _____
Phone Number: _____

*Name:*_____ *Connection/Role:* _____
*Phone Number:*_____

There may be health care professionals or family members that have made decisions that were not according to your wishes in the past. They could inadvertently get involved if you don't include the following: *"I do NOT want the following people involved in any way in my care or treatment:"*

*Name:*_____
*Why you do NOT want them involved (optional):*_____
_____
_____

*Name:*_____
*Why you do NOT want them involved (optional):*_____
_____
_____

*Name:*_____
*Why you do NOT want them involved (optional):*_____
_____
_____

*Name:*_____
*Why you do NOT want them involved (optional):*_____
_____
_____

*Name:*_____
*Why you do NOT want them involved (optional):*_____
_____
_____

Settling Disputes Between Supporters – You might like to include a section that describes how you want possible disputes between supporters settled. For instance, you may want to say that a majority need to agree, or that a particular person or two people make the determination.

_____
_____
_____
_____
_____
_____
_____
_____

Part 4 – *Medications*

Physician _____ *Phone Number:*_____
Physician _____ *Phone Number:* _____
Physician _____*Phone Number:*_____
Physician _____*Phone Number:* _____
Pharmacy _____ *Phone Number:* _____

List the medications you are currently taking and why you are taking them. Include the name of the doctor and the pharmacy.

_____
_____
_____
_____
_____
_____

List those medications you would prefer to take if medications or additional medications became necessary, and why you would choose those.

_____
_____
_____
_____
_____

List those medications that must be avoided and give the reasons:

_____
_____
_____
_____
_____
_____
_____

Part 5 – Treatments

List treatments that help reduce your symptoms and when they should be used.

List treatments you would want to avoid.

Part 6 – Home/Community Care/Respite Center

Set up a plan so that you can stay at home or in the community and still get the care you need.

Part 7 – Treatment Facilities

List treatment facilities where you prefer to be treated or hospitalized if that becomes necessary.

List treatment facilities you want to avoid.

Part 8 – Help from others

List those things that others can do for you that would help reduce your symptoms or make your more comfortable.

List those things you need others to do for you and who you want to do what.

What I need done:	*Who I'd like to do it:*

List those things that others might do, or have done in the past, that would not help or might even worsen your symptoms.

Part 9 – Inactivating the Plan

Describe symptoms, lack of symptoms or actions that indicate supporters no longer need to use this plan.

Part 10 – If I am in Danger

If my behavior endangers me or others I want my supporter to:

You can help assure that your crisis plan will be followed by signing it in the presence of two witnesses. It will further increase its potential for use if you appoint and name a durable power of attorney.

I developed this plan on (date) _____
with the help of _____

_____

Any plan with a more recent date supersedes this one.
Signed: _____ Date: _____
Witness: _____ Date: _____
Witness: _____ Date: _____
Attorney: _____ Date: _____

Durable Power of Attorney (if you have one)
Name: _____ Date: _____
Phone Number: _____