My Health Action Plan

I will have my provider fill this out with me

**** Keep Accessible for Caregivers ****

Date of Plan:

Name:

Address:

Phone Number(s):

In Case of Emergency Call:

Name: Relationship: Phone:

Name: Relationship: Phone:

Emergency Mobile Crisis Phone #:

Police Department Phone #:

Fire Department Phone #:

Rescue Ambulance Phone #:

Poison Control Phone #:

Therapist's Name & Phone #:

Health Insurance/Medicaid Information:

Connecticut Behavioral Health Partnership Wellness Care Coordination Program:
1-877-552-8247, TTY 1-866-218-0525

Current Medical Contact Information

Current Diagnosis(es) if known:

Medical Diagnosis: Date:

Behavioral Health Diagnosis: Date:

Current Goals and Priorities: Date:

Primary Physician's Office: Contact Information

PCP Name: Phone:

Address: Nurse's Name:

Specialist Provider's Office: Contact Information

Name: Phone:

Specialty:

Address:

Name: Phone:

Specialty:

Address:

Pharmacy Contact Information:

Name: Phone:

Address:

(OVER)

My Medicine and Medical Summary

I will tell my provider if I have any problems taking my medicines or any new symptoms.

Medicines I am currently taking

Name of my medicine	Date Started	Dosage (How much)	How Often	Purpose (Why)	Any Side Effects

Allergies I have

Allergy to:	Reaction:
Allergy to:	Reaction:
Allergy to:	Reaction:

Medicines I used to take

Name of my medicine	Date Started	Dosage (How much)	How Often	Purpose (Why)	Any Side Effects

My Medical Summary

Medical/Special Needs (Providers should take into consideration any health issue or special needs when working with the member.)

Select all applicable options:

- ❑ Asthma
- ❑ Autism/PDD Spectrum
- ❑ Brain Injury
- ❑ Cirrhosis
- ❑ Chronic Obstructive Pulmonary Disease (COPD)
- ❑ Congestive Heart Failure (CHF)
- ❑ Coronary Artery Disease (CAD)
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Hepatitis
- ❑ Hypertension
- ❑ Obesity
- ❑ Post Partum Depression
- ❑ Pregnancy/High Risk Pregnancy
- ❑ Seizure Disorder
- ❑ Other

Please Specify: ______________________________

Medical Related Action Items for Me to Follow

Things I will do after talking with my provider:

- ❑ Keep my appointments with my provider.
- ❑ Take my medications on time every day.
- ❑ If I smoke, I should quit.
- ❑ Eat less red meat.
- ❑ Exercise for _______ minutes _______ times each week.
- ❑ Get a flu shot every year.
- ❑ Get a pneumonia shot.
- ❑ Eat foods low in salt.
- ❑ Stop adding salt at the table.

Call my provider today if:

- ❑ I have gained 3 pounds overnight or 5 pounds in 1 week.
- ❑ I have changes in my cough or the color of my spit (or blood in it).
- ❑ I have a fever above 101.
- ❑ I have new trouble with my breathing.
- ❑ My blood sugar is higher than _______ or lower than _______.
- ❑ My chest pain (angina) is different than usual.

I know to call 911 if I have signs of a heart attack.

- Pressure, squeezing, fullness or pain in my chest that lasts for more than a few minutes or goes away and comes back.
- Pressure or chest pain that does not go away with nitro (nitroglycerin medicine).
- Pain or discomfort in one or both arms, shoulders, jaw or stomach.
- Having trouble breathing.
- Breaking out in a cold sweat, feeling sick to my stomach or lightheaded.

I know to call 911 if I have signs of a stroke.

- Sudden weakness or numbness of my face, arm or leg, especially on one side of my body.
- Sudden trouble thinking, talking or understanding.
- Sudden trouble seeing in one or both eyes.
- Sudden severe headache with no known cause.
- Sudden dizziness or trouble walking.

I will know my numbers!

My blood pressure: ______________________	My target is: ______________________
My weight: ______________________	My target is: ______________________
My A1C (diabetes) ______________________	My target is: ______________________
My HDL (good cholesterol) ______________	My target is: ______________________
My LDL (bad cholesterol) ________________	My target is: ______________________

(OVER)

Wellness & Recovery Plan

Safety Concerns (Any information either about the member, family or living situation, which should be known when member is in crisis.):

Select all applicable options:

- ❑ Access to Weapons
- ❑ Current Charges Pending
- ❑ Current Parole
- ❑ History/Current JJ Involvement
- ❑ History of Homicide Attempt(s)
- ❑ History of Arrests
- ❑ History of Police Interventions
- ❑ History of Suicide Attempt(s)
- ❑ Substance use
- ❑ Volatile Home Environment

Please Specify: ______________________________

____

Substance use (Past or present substance use issues):

- ❑ Current Alcohol
- ❑ Current Marijuana
- ❑ Current Other Illicit
- ❑ Current Prescription Drugs
- ❑ Family Members with Substance Abuse
- ❑ Past Alcohol
- ❑ Past Marijuana
- ❑ Past Other Illicit
- ❑ Past Prescription Drugs
- ❑ Other

Please Specify: ______________________________

____

Triggers/Risk Factors ("Red Flags"/Stressors that may trigger a crisis):

Select all applicable options:

- ❑ Change in Schedule
- ❑ Change in Treatment Providers
- ❑ Criticizing/Scolding
- ❑ Family Interaction
- ❑ Over-stimulating Environment
- ❑ Peer Conflict
- ❑ Police/Legal Involvement
- ❑ Recent Loss/Trauma
- ❑ Rejection
- ❑ School/Work Difficulty
- ❑ Substance use
- ❑ Other

Additional Information: ______________________________

____

Reactive Crisis Planning (Interventions/steps successfully utilized in the past to resolve crisis; using members strengths and support systems)

Additional Information (list specific steps/interventions successful in the past): ______________________________

____

Please specify specific steps to take to prevent crisis
(i.e. call EMPS, Mobile Crisis, 211, contact current provider, provider timeout, etc.):

____

____

Is this Wellness recovery Crisis Plan form used by provider and/or member:_______________

Provider Name (print) and Signature: Date:

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