

# 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:

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

Please Specify:

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# 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: _____

# 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:

- |   |  |
|---|--|
| <input type="checkbox"/> Access to Weapons              | <input type="checkbox"/> History of Arrests              |
| <input type="checkbox"/> Current Charges Pending        | <input type="checkbox"/> History of Police Interventions |
| <input type="checkbox"/> Current Parole                 | <input type="checkbox"/> History of Suicide Attempt(s)   |
| <input type="checkbox"/> History/Current JJ Involvement | <input type="checkbox"/> Substance use                   |
| <input type="checkbox"/> History of Homicide Attempt(s) | <input type="checkbox"/> Volatile Home Environment       |

Please Specify:

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**Substance use** (Past or present substance use issues):

- |  |  |
|--|--|
| <input type="checkbox"/> Current Alcohol                     | <input type="checkbox"/> Past Alcohol            |
| <input type="checkbox"/> Current Marijuana                   | <input type="checkbox"/> Past Marijuana          |
| <input type="checkbox"/> Current Other Illicit               | <input type="checkbox"/> Past Other Illicit      |
| <input type="checkbox"/> Current Prescription Drugs          | <input type="checkbox"/> Past Prescription Drugs |
| <input type="checkbox"/> Family Members with Substance Abuse | <input type="checkbox"/> Other                   |

Please Specify:

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

Select all applicable options:

- |  |   |
|--|---|
| <input type="checkbox"/> Change in Schedule            | <input type="checkbox"/> Police/Legal Involvement |
| <input type="checkbox"/> Change in Treatment Providers | <input type="checkbox"/> Recent Loss/Trauma       |
| <input type="checkbox"/> Criticizing/Scolding          | <input type="checkbox"/> Rejection                |
| <input type="checkbox"/> Family Interaction            | <input type="checkbox"/> School/Work Difficulty   |
| <input type="checkbox"/> Over-stimulating Environment  | <input type="checkbox"/> Substance use            |
| <input type="checkbox"/> Peer Conflict                 | <input type="checkbox"/> Other                    |

Additional Information:

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**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):

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

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

Provider Name (print) and Signature: \_\_\_\_\_

Date: \_\_\_\_\_