Personal Crisis Plan (Advance Directive)

(To be used if the circumstances described on page 2 of this document occur.)

Name ___________________________________ Date ____________

Part 1 What I'm like when I'm feeling well.

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Part 2 Signs I Need My Supporters to Take Over

If I have several of the following signs and/or symptoms, my supporters, named on the next page, need to take over responsibility for my care and make decisions in my behalf based on the information in this plan.

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Part 3 Supporters

If this plan needs to be activated, I want the following people to take over for me:

Name Connection/Role Phone Number

____

Specific Tasks for this Person

____

____

Name Connection/Role Phone Number

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Specific Tasks for this Person

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Name Connection/Role Phone Number

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Specific Tasks for this Person

____

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Name Connection/Role Phone Number

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Specific Tasks for this Person

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Name Connection/Role Phone Number

____

Specific Tasks for this Person

____

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Name Connection/Role Phone Number

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Specific Tasks for this Person

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I <u>do not</u> want the following people involved in any way in my care or treatment:

Name I don't want them involved because: (optional)

____

Name I don't want them involved because: (optional)

____

Name I don't want them involved because: (optional)

____

Settling Disputes Between Supporters

If my supporters disagree on a course of action to be followed, I would like the dispute to be settled in the following way:____

____

____

____

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Part 4 Medications / Supplements / Health Care Preparations

Physician ______________________ Psychiatrist ________________________

Other Health Care Providers

____

____

____

____

Pharmacy ______________________ Pharmacist ______________________________

Allergies ____

____

Insurance Information ____

Medication / Supplement / Health Care Preparation I am currently using

Dosage____

Purpose ____

Medication / Supplement / Health Care Preparation I am currently using

Dosage____

Purpose____

Medication / Supplement / Health Care Preparation I am currently using

Dosage____

Purpose____

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Medcation / Supplement / Health Care Preparation I am currently using

Dosage____

Purpose____

Medication / Supplement / Health Care Preparation I am currently using

Dosage____

Purpose____

Medication / Supplement / Health Care Preparation which is acceptable if needed

Dosage____

Purpose____

Medication / Supplement / Health Care Preparation which is acceptable if needed

Dosage____

Purpose ____

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

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****take special note****

Other comments about medications, supplements, or health care preparations:

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Part 5 Treatments and Complementary Therapies

Treatment/Complementary Therapy

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When and how to use this treatment/complementary therapy

____

____

Treatment/Complementary Therapy

____

When and how to use this treatment/complementary therapy

____

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Treatment/Complementary Therapy

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When and how to use this treatment/complementary therapy

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Part 6 Home Care / Community Care / Respite Center

If possible, follow the following care plan:

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Part 7 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

____

____

____

____

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Part 8 Help from Others

Please do the following things that would help reduce my uncomfortable feelings, make me more comfortable, and keep me safe.

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I need (name the person) ___________________ to (task) __________________________

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I need (name the person) __________________ to (task) _________________________

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I need (name the person) __________________ to (task) _________________________

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I need (name the person) __________________ to (task) _________________________

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I need (name the person) __________________ to (task) _________________________

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I need (name the person) __________________ to (task) _________________________

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I need (name the person) __________________ to (task) _________________________

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Do not do the following. It won't help and it may even make things worse.

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Part 9 Inactivating the Plan

The following signs or actions indicate that my supporters no longer need to use this plan.

____

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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____

Substitute for Durable Power of Attorney ___________________________________

Any Personal Crisis Plan developed on a date after the dates listed above takes precedence over this document.

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