|  |
| --- |
| **Relapse prevention plan** |
| Name:  | Last time discussed: |
| Phone: |  |
| **Stress factors/causes:** |
|  |  |
|  |  |
| **Stable and neutral phase** |
| What do I notice myself: | What I can do: |
|  |  |
|  |  |
|  |  |
|  |  |
| **1st signs of a possible ............** |
| What do I notice myself: | What I can do: |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| What another person notices: | What others can do: |
|  |  |
|  |  |
|  |  |
| **Light .............. phase** |
| What do I notice myself: | What I can do: |
|  |  |
|  |  |
| What another person notices: | What others can do: |
|  |  |
|  |  |
| **Moderate .............. phase** |
| What do I notice myself: | What I can do: |
|  |  |
|  |  |
| What another person notices: | What others can do: |
|  |  |
|  |  |
| **Severe .............. phase** |
| What do I notice myself: | What I can do: |
|  |  |
|  |  |
| What another person notices: | What others can do: |
|  |  |
| **Important phone numbers** |
| Those concerned 1: | Nurse:  |
| Those concerned 2: | Physician/Psychiatrist: |
|   | General practice center: |