|  |  |  |
| --- | --- | --- |
| **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: | |