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.

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

_____

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

_____

_____

Name Connection/Role Phone Number

_____

Specific Tasks for this Person

_____

_____

I do not 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:_____

_____

_____

____

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_____

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?

_____

_____

_____

_____

_____

****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

_____

When and how to use this treatment/complementary therapy

_____

_____

Treatment/Complementary Therapy

_____

When and how to use this treatment/complementary therapy

_____

_____

Treatment/Complementary Therapy

When and how to use this treatment/complementary therapy

Part 6 Home Care / Community Care / Respite Center

If possible, follow the following care plan:

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

_____

_____

_____

_____

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) _____

_____

I need (name the person) _____ to (task) _____

_____

I need (name the person) _____ to (task) _____

_____

I need (name the person) _____ to (task) _____

_____

I need (name the person) _____ to (task) _____

_____

I need (name the person) _____ to (task) _____

_____

I need (name the person) _____ to (task) _____

_____

Do <u>not</u> 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.

_____

_____

_____

_____

_____

_____

_____

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.