Wellness Recovery Action Plan

(WRAP)

Name: _____ Date: _____

Wellness Toolbox

What I'm Like When I'm Feeling Well

Daily Maintenance List

Things to Consider Doing Each Day to Relieve Stress and Maintain My Wellness/Recovery

Triggers

Triggers Action Plan

Early Warning Signs

Early Warning Signs Action Plan

Feeling Much Worse

Action Plan for Helping Myself to Feel Better When I am Feeling Much Worse

Crisis Plan

What I'm Like When I'm Feeling Well.

I need help when I:

Supporters

Name _____

Address _____

Phone Number _____

Area of expertise or specific task I would like them to take care of

Name _____

Address _____

Phone Number _____

Area of expertise or specific task I would like them to take care of

Name _____

Address _____

Phone Number _____

Area of expertise or specific task I would like them to take care of

Name _____

Address _____

Phone Number _____

Area of expertise or specific task I would like them to take care of

Supporters - continued

Name _____

Address _____

Phone Number _____

Area of expertise or specific task I would like them to take care of

Name _____

Address _____

Phone Number _____

Area of expertise or specific task I would like them to take care of

Name _____

Address _____

Phone Number _____

Area of expertise or specific task I would like them to take care of

Name _____

Address _____

Phone Number _____

Area of expertise or specific task I would like them to take care of

I do not want the following people involved in any way in my care or treatment.

Name	Why I do not want them involved (optional)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Also, list those people you want your supporters to notify if you are in a crisis, such as your employer or family members--along with what to tell each of them.

People to Notify

Please notify	Tell them
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How I want disputes between my supporters settled

Medical Information/Medications / Supplements / Health Care Preparations

Physician

Name _____ Phone number _____

Psychiatrist

Name _____ Phone number _____

Other Health Care Providers

Name _____ Phone number _____

Area of expertise _____

Name _____ Phone number _____

Area of expertise _____

Name _____ Phone number _____

Area of expertise _____

Pharmacy _____ Phone number _____

Allergies

Insurance numbers and other insurance information

Medication / Supplement / Health Care Preparations

Name _____ Dosage _____

Purpose

Name _____ Dosage _____

Purpose

Name _____ Dosage _____

Purpose

Name _____ Dosage _____

Purpose

Name _____ Dosage _____

Purpose

Name _____ Dosage _____

Purpose

Name _____ Dosage _____

Purpose

Medication / Supplement / Health Care Preparation to be used if needed

Name _____ Dosage _____

When to use _____

Name _____ Dosage _____

When to use _____

Name _____ Dosage _____

When to use _____

Name _____ Dosage _____

When to use _____

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

Name _____

Should be avoided because _____

Name _____

Should be avoided because _____

Name _____

Should be avoided because _____

Name _____

Should be avoided because _____

Name _____

Should be avoided because _____

****take special note**

Treatments and Complementary Therapies

Treatment/Complementary Therapy

Name _____

When and how to arrange for use

Name _____

When and how to arrange for use

Name _____

When and how to arrange for use

Name _____

When and how to arrange for use

Name _____

When and how to arrange for use

Name _____

When and how to arrange for use

Name _____

When and how to arrange for use

Home/Community Care/Respite Center

If possible, help me use the following care plan:

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

Name _____

Contact Person _____

Phone Number _____

I prefer this facility because

Avoid using the following hospital or treatment facilities

Name	Reason to avoid using
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Help From Others

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

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

When My Supporters No Longer Need To Use This Plan

The following signs, lack of symptoms 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 _____

POST CRISIS PLAN

How I would like to feel when I have recovered from this crisis.

You may want to refer to the first section of your Wellness Recovery Action Plan, What I Am Like When I Am Well. This may be different from what you feel like when you are well since your perspective may have changed during this crisis.

I will know that I am "out of the crisis" and ready to use this Post Crisis Plan when I:

Post Recovery Supporters List

I would like the following people to support me if possible during this post crisis time.

Who	Phone Number	What I need them to do
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Arriving At Home (if you have been hospitalized or away from home)

If you have been hospitalized, your first few hours at home are very important.

Do you feel you will feel safe and be safe at home? ☐ Yes ☐ No

If your answer is no, what will you do to insure that you will feel and be safe at home?

Things I must take care of as soon as I get home.

Things I can ask someone else to do for me.

Things that can wait until I feel better.

Things I need to do for myself every day while I am recovering from crisis.

Things I might need to do every day while I am recovering from this crisis.

Things and people I need to avoid while I am recovering from this crisis.

Signs that I may be beginning to feel worse (anxiety, excessive worry, overeating, sleep disturbances).

Wellness Tools I will use if I am starting to feel worse. Star those that you must do. The others are choices.

Issues to Consider

What do I need to do to prevent further repercussions from this crisis and when I will do these things.

People I need to thank.

Person	When I will thank them	How I will thank them
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

People I need to apologize to.

Person	When I will apologize	How I will apologize
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

People with whom I need to make amends.

Person	When I will apologize	How I will apologize
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical, legal, or financial issues that need to be resolved.

Issue	How I plan to resolve this issue
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Things I need to do to prevent further loss (cancel credit cards, get official leave from work if it was abandoned, cut ties with destructive friends, etc.).

Timetable for Resuming Responsibilities

There is a worksheet at the end of these forms that may assist you in this process.

SAMPLE
(e.g. child care, pet care, job, cooking, household chores, etc.)

Responsibility	Plan for resuming this responsibility
Work	In 3 days go back to work for 2 hours a day for 5 days For one week go back to work half time For one week work 3/4 time Resume full work schedule

Responsibility _____

Who has been doing this while I was in crisis? _____
While I am resuming this responsibility, I need (who) to:

Plan for resuming responsibility:

Responsibility _____

Who has been doing this while I was in crisis? _____
While I am resuming this responsibility, I need (who) to:

Plan for resuming responsibility:

Responsibility _____

Who has been doing this while I was in crisis? _____
While I am resuming this responsibility, I need (who) to:

Plan for resuming responsibility:

Responsibility _____

Who has been doing this while I was in crisis? _____
While I am resuming this responsibility, I need (who) to:

Plan for resuming responsibility:

Responsibility _____

Who has been doing this while I was in crisis? _____
While I am resuming this responsibility, I need (who) to:

Plan for resuming responsibility:

Responsibility _____

Who has been doing this while I was in crisis? _____
While I am resuming this responsibility, I need (who) to:

Plan for resuming responsibility:

Responsibility _____

Who has been doing this while I was in crisis? _____
While I am resuming this responsibility, I need (who) to:

Plan for resuming responsibility:

Other issues I may want to consider

Signs that this post crisis phase is over and I can return to my Daily Maintenance Plan as my guide to things to do for myself every day.

Changes in my Wellness Recovery Action Plan℠ that might help prevent this crisis in the future.

Changes in my Crisis Plan that might ease my recovery.

Changes I want to make in my lifestyle or life goals.

What did I learn from this crisis?

Are there changes I want or need to make in my life as a result of what I have learned?

If so, when and how will I make these changes?

Post Crisis Planning Worksheet

Task/Responsibility	Steps	When you would like to take this step
_____	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
_____	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
_____	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
_____	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____