Wellness Plan

Name:	Health Card #:
Address:	
	Primary Language:
City:	
Postal Code:	Cultural Needs:
Phone:	
Date of Birth:	Spiritual Needs:
Number of Dependent(s) under my care:	

Name:	Age:	Relationship

Living Situation:

☐ On Own	☐ Group home	☐ Small options
☐ With Family	☐ Licensed Boarding Home	☐ Shelter
☐ Supported Apt.	☐ Hospital	☐ Other

Psychiatric Diagnosis(es):	**Allergies/Reactions:**
Physical Diagnosis(es):	**Other Health Concerns:**

Key Contacts

Primary Mental Health Worker: _____Service/Agency:_____
Address: _____
Phone#:

Psychiatrist: _____Service/Agency: _____
Address: _____
Phone #:

Family Doctor: _____ Service/Agency: _____
Address: _____
Phone #:

Emergency Contact: _____ Relationship: _____
Address: _____
_____Phone #:_____

Next of Kin: _____Relationship:_____
Address: _____
Phone #:

Housing Support Worker:_____ Service/Agency: _____
Address: _____
Phone #:

Income Source(s):

Service/Agency/Employer:	**Key Contact:**	**Phone#:**

Peer Support Contact(s):

Formal/Informal:	**Relationship:**	**Phone#:**

Other Contact: _____Relationship: _____
Address: _____
Phone#:

Medication Arrangements:

Doctor ordering **Psychiatric** Meds:	Doctor ordering **Medical** Meds:	Pharmacy (name, address, phone#)
☐ Pick up meds at Pharmacy ☐ Delivery of meds at home	Injection: ☐ No ☐ Yes, frequency _____	If injection (when, where, by whom)

Assistance required in my daily routine,

e.g., medications, meals, self-care, mobility:

Type of Assistance Needed:	Who Helps Me?	When/How often?

1. What do I and/or others do to help me stay well mentally?
2. What are the <u>early signs</u> that I am becoming unwell?
3. What do I and/or others need to do if I experience these early signs?
4. What are the stressors/situations in my life that may cause me to become unwell?
5. What do I and/or others need to do if I get into these situations?
6. If I need to go in hospital, whom do I want to come with me? (list name, relationship, phone #.)
7. Important things to know or do if I get sick and need to go to the hospital (e.g., rent, bills, pets, employer, dependents, family):
8. When my crisis situation is over, what would help me get back into my daily routine?

Advance Directives

9 a) I have an Advance Directive or "Living Will" which describes my wishes and preferences about my health care and treatment.

☐ Yes ☐ No, go to question #10 a)

9 b) If yes, did you choose a substitute decision maker?

☐ Yes ☐ No

9 c) If yes, what is the name of your substitute decision maker?

Name: _____

Relationship: _____

Phone #: _____

10 a) I am interested in learning more about Advance Directives or "Living Will".

☐ Yes ☐ No

10 b) If yes, have you been provided me with the "Advance Directives Educational Booklet"?

☐Yes ☐ No

Questions to ask yourself when revising your Wellness Plan, which should be completed every 6 month to 1 year, or when a significant change occurs in your life:

1. Did I learn anything new about myself and ways to deal with my illness?
2. What worked well during a crisis situation?
3. What did not work well during a crisis situation?
4. Do I need to make changes on my Wellness Plan according to what I learned about myself?