Portable Treatment Record

Name: Date of birth:

## Emergency contacts

|  |
| --- |
| Name: Phone: |
| Relationship: |

Name: Phone:

|  |
| --- |
| Relationship: |
| Pharmacy: Phone: |
| Location: |

**Primary care physician**

|  |
| --- |
| Name: Phone: |
| Office address: |

**Psychiatrist**

|  |
| --- |
| Name: Phone: |
| Office address: |

**Other mental health professionals (therapist, case manager, psychologist, etc.)**

|  |
| --- |
| Name: Phone: |
| Type of mental health professional: |
| Office address: |
| Name: Phone: |

|  |
| --- |
| Type of mental health professional: |
|  Office address: Name: Phone: |

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Medical History

# Allergies to medications:

|  |
| --- |
| **Medication Reaction** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Psychiatric medications that caused severe side effects:**

**Approximate date discontinued**

**Side effects**

**Medication**

|  |  |  |
| --- | --- | --- |
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**Major medical illnesses:**

**Illness Treatment Current status**

|  |  |  |
| --- | --- | --- |
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**Major medical procedures (ex: surgeries, MRI, CT scan)**

**Date Procedure Result**

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| --- | --- | --- |
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Current Medical Information

# Diagnosis:

**Date Procedure Who made the diagnosis**

|  |  |  |
| --- | --- | --- |
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**Psychiatric hospitalizations:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of** | **Reason for** | **Name of facility** | **Date of** |
| **admission** | **hospitalization** |  | **discharge** |

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Medication Record

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Physician** | **Medication** | **Dosage** | **Date** |
| **prescribed** |  |  |  | **discontinued** |

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Crisis Plan

|  |
| --- |
| **Emergency resource 1:** |
| Phone: Cell phone |

|  |
| --- |
| **Emergency resource 2:** |
| Phone: Cell phone: |

**Physician: Phone:**

**If we need help from professionals, we will follow these steps (include how the children and other vulnerable family members will be taken care of):**

 **1.**

 **2.**

 **3.**

 **4.**

 **5.**

**When will we think about going to the hospital?** What type of behavior would make us consider doing this?

**When will we think about calling 911?** What type of behavior would make us consider doing this?

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Relapse Plan

The person with the mental health condition and the family should talk together and agree on the following parts of their plan:

**How do we know the symptoms are returning?** List signs and symptoms of relapse:

|  |
| --- |
| **1.** |
| **2.** |
| **3.** |

## When the symptoms on line 1 appear, we will:

|  |
| --- |
| **♦** |
| **♦** |
| **♦** |

**When the symptoms on line 2 appear, we will:**

|  |
| --- |
| **♦** |
| **♦** |
| **♦** |

**When the symptoms on line 3 appear, we will:**

|  |
| --- |
| **♦** |
| **♦** |
| **♦** |

**When will we think about going to the hospital?** What type of behavior would make us consider doing this?

**When will we think about calling 911?** What type of behavior would make us consider doing this?

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