Portable Treatment Record

Name:	Date of birth:
Emergency contacts	
Name:	Phone:
Relationship:	
Name:	Phone:
Deletionship	
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:

Medical History

Allergies to medications:

Medication	Reaction

Psychiatric medications that caused severe side effects:

Medication	Side effects	Approximate date discontinued

Major medical illnesses:

lliness	Treatment	Current status

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

Date	Procedure	Result

Current Medical Information

Diagnosis:

Date	Procedure	Who made the diagnosis

Psychiatric hospitalizations:

Date of admission	Reason for hospitalization	Name of facility	Date of discharge

Medication Record

Date prescribed	Physician	Medication	Dosage	Date discontinued

Crisis Plan

Cell phone
Cell phone:
Phone:
these steps (include how the children and other

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?

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, v	ve 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?