# My Relapse Prevention Plan

**Name:** _____ **Date:** _____

## Maintenance Medications

| | | | | |
|---|---|---|---|---|
| 1. | ; | tablet(s) of | mg | Take at least until |
| 2. | ; | tablet(s) of | mg | Take at least until |
| 3. | ; | tablet(s) of | mg | Take at least until |
| 4. | ; | tablet(s) of | mg | Take at least until |

Call your treating provider or behavioral health care manager with any questions or if you are thinking about stopping a medication (see contact information below).

## Other Treatments

1.

2.

3.

## Personal Warning Signs

1.

2.

3.

4.

## Things I do to Prevent Depression/Anxiety

1.

2.

3.

4.

**If symptoms return, contact:** _____

## Contact Information

| | | |
|---|---|---|
| Treating Provider | Name | Number |
| Behavioral Health Care Manager | Name | Number |

### Next Appointment

Date _____ Time _____ Location _____