My Relapse Prevention Plan

Today's Date: _____ **Patient Name:** _____

I will keep my plan:

I will share my plan with:

I will review my plan:

Maintenance Medications

- *I will take <#> tablets of <dose mg> of <medication name> until <date>*
- I will take < > tablets of < mg> of < > until < / / >
- I will take < > tablets of < mg> of < > until < / / >
- I will take < > tablets of < mg> of < > 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).

Things I do to prevent symptoms from returning:

1.)

2.)

3.)

4.)

Personal Warning Signs:

1.)

2.)

3.)

4.) My PHQ-9 score is ____ or higher and/or my GAD-7 score is ____ or higher.

Things I can do when I notice my warning signs:

1.)

2.)

3.)

4.)

If symptoms return, contact:

Treating Provider Name:

Phone Number:

BHCM Name:

Phone Number:

Next Appointment Date:_____ **Time:** _____ **Location:** _____

PRISM

Assess Your Symptoms Regularly

Use the screening tools below to assess yourself for symptoms of depression (PHQ-9) and anxiety (GAD-7). Compare today's score to the score identified under your personal warning signs.

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add columns				
Total				

Generalized Anxiety Disorder Questionnaire (GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add columns				
Total				