Personal Crisis Plan (Advance Directive)

(To be used if the circumstances described on page 2 of this document occur.)

Name ___________________________________    Date ____________

Part 1  What I’m like when I’m feeling well.

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Part 2  

Signs I Need My Supporters to Take Over

If I have several of the following signs and/or symptoms, my supporters, named on the next page, need to take over responsibility for my care and make decisions in my behalf based on the information in this plan.
Part 3  Supporters

If this plan needs to be activated, I want the following people to take over for me:

<table>
<thead>
<tr>
<th>Name</th>
<th>Connection/Role</th>
<th>Phone Number</th>
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Specific Tasks for this Person

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**I do not** want the following people involved in any way in my care or treatment:

<table>
<thead>
<tr>
<th>Name</th>
<th>I don’t want them involved because: (optional)</th>
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**Settling Disputes Between Supporters**

If my supporters disagree on a course of action to be followed, I would like the dispute to be settled in the following way:

| ____________________________________________________________ |
| ____________________________________________________________ |
| ____________________________________________________________ |
| ____________________________________________________________ |

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Part 4  Medications / Supplements / Health Care Preparations

Physician ______________________ Psychiatrist ________________________

Other Health Care Providers

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Pharmacy ______________________ Pharmacist ____________________________

Allergies

________________________________________________________________________
________________________________________________________________________

Insurance Information

Medication / Supplement / Health Care Preparation  I am currently using

Dosage

Purpose

Medication / Supplement / Health Care Preparation  I am currently using

Dosage

Purpose

Medication / Supplement / Health Care Preparation  I am currently using

Dosage

Purpose
Medication / Supplement / Health Care Preparation

I am currently using:

** Dosage

** Purpose

Medication / Supplement / Health Care Preparation which is acceptable if needed:

** Dosage

** Purpose

Medication / Supplement / Health Care Preparation which is acceptable if needed:

** Dosage

** Purpose

Medication / Supplement / Health Care Preparation which is acceptable if needed:

** Dosage

** Purpose

Medication / Supplement / Health Care Preparation which is acceptable if needed:

** Dosage

** Purpose

Medication / Supplement / Health Care Preparation which I am currently using:

** Dosage

** Purpose
**take special note**

Other comments about medications, supplements, or health care preparations:

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
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_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Part 5  Treatments and Complementary Therapies

Treatment/Complementary Therapy

_______________________________________________________________________

When and how to use this treatment/complementary therapy

_______________________________________________________________________

Treatment/Complementary Therapy

_______________________________________________________________________

When and how to use this treatment/complementary therapy

_______________________________________________________________________
Treatment/Complementary Therapy

When and how to use this treatment/complementary therapy

Part 6 Home Care / Community Care / Respite Center

If possible, follow the following care plan:

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Part 7 Hospital or other Treatment Facilities.

If I need hospitalization or treatment in a treatment facility, I prefer the following facilities, in order of preference:

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Person</th>
<th>Phone Number</th>
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I prefer this facility because

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Avoid using the following hospitals or treatment facilities:

<table>
<thead>
<tr>
<th>Name</th>
<th>Reason to avoid using</th>
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Part 8 Help from Others

Please do the following things that would help reduce my uncomfortable feelings, make me more comfortable, and keep me safe.

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_______________________________________________________________________

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I need (name the person) _______________________ to (task) _______________________

_______________________________________________________________________

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I need (name the person) __________________ to (task) ________________________________
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Do not do the following. It won’t help and it may even make things worse.
_________________________________________________________________________________
_________________________________________________________________________________
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Part 9    Inactivating the Plan

The following signs or actions indicate that my supporters no longer need to use this plan.
_______________________________________________________________________
_______________________________________________________________________
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_______________________________________________________________________

I developed this plan on (date) _______________________________ with the help of
_______________________________________________________________________

Any plan with a more recent date supersedes this one.

Signed ________________________________  Date __________________

Witness ________________________________  Date __________________

Witness ________________________________  Date __________________

Attorney ________________________________  Date __________________

Durable Power of Attorney__________________________

Substitute for Durable Power of Attorney __________________________

Any Personal Crisis Plan developed on a date after the dates listed above takes precedence over this document.