

Recovery x-Change  
[www.recoveryxchange.org](http://www.recoveryxchange.org)

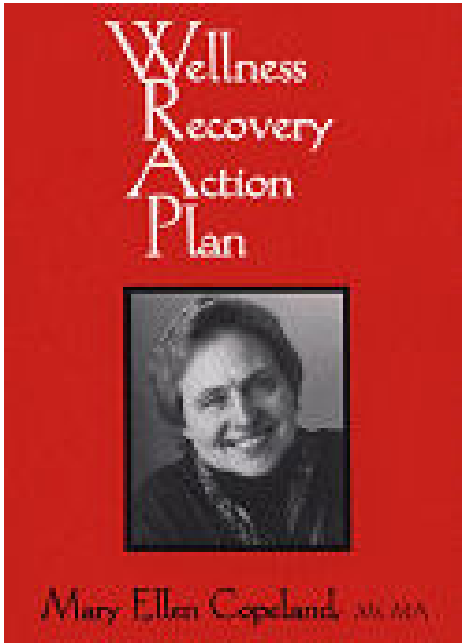


Mary Ellen Copeland's



# W.R.A.P

## Wellness Recovery Action Plan



# Workbook

Designed by: [david@recoveryxchange.org](mailto:david@recoveryxchange.org)  
Recovery x-Change: where recovery isn't just a dream!























# Recovery x-Change: where recovery come to life!



## Crisis Plan: Part 3



NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

LIST AT LEAST 5 PEOPLE – PREFERABLY THOSE FROM YOUR SUPPORT NETWORK THAT YOU'D WANT TO TAKE OVER FOR YOU IN THE EVENT OF A CRISIS.

MAKE SURE YOU ASK THEM IF IT IS O.K. FOR YOU TO INCLUDE THEM ON YOUR LIST. TELL THEM WHAT WOULD BE INVOLVED AND SHOW THEM A COPY OF YOUR PLAN.

### SUPPORTERS:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

INCLUDE A LIST OF THE PEOPLE YOU **DO NOT WANT** INVOLVED IN YOUR CARE. YOU CAN ALSO WRITE WHY YOU DO NOT WANT THEM INVOLVED.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

WHY? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Crisis Plan: Part 4**



Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Medications:**

Provide names, phone numbers of physician, pharmacy, Insurance Company's name, phone number and ID number, (Include allergies).

Doctor: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

ID number: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications and healthcare preparations you are currently using, why you use them, the dosage, and when you take them.

Medication: \_\_\_\_\_ Prescribed for: \_\_\_\_\_

Dosage: \_\_\_\_\_ How often? \_\_\_\_\_

Medication: \_\_\_\_\_ Prescribed for: \_\_\_\_\_

Dosage: \_\_\_\_\_ How often? \_\_\_\_\_

Medication: \_\_\_\_\_ Prescribed for: \_\_\_\_\_

Dosage: \_\_\_\_\_ How often? \_\_\_\_\_

Medication: \_\_\_\_\_ Prescribed for: \_\_\_\_\_

Dosage: \_\_\_\_\_ How often? \_\_\_\_\_

Medication: \_\_\_\_\_ Prescribed for: \_\_\_\_\_

Dosage: \_\_\_\_\_ How often? \_\_\_\_\_



## Recovery x-Change: where recovery comes to life!



### Crisis Plan: Parts 5, 6 & 7



**5: Treatments:** List those treatments you would prefer and those you would want to avoid. Include alternative therapies that have *as those that have not been helpful*:

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**6: Community Care:** Hospitalization is often not the best option. Develop a carefully devised plan so that you can stay at home or in the community and still get the care you need. In order to do this, find out what resources are available in your community that you would prefer:

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**7: Treatment Facilities:** List those treatment facilities where you prefer to be hospitalized if that becomes necessary, and those you wish to avoid.

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# Recovery x-Change: where recovery comes to life!



## Crisis Plan Part: 8



**HELP FROM OTHERS:** LIST THE THINGS THAT OTHERS CAN DO FOR YOU THAT WOULD HELP TO FEEL BETTER.

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List those things you need others to do for you - such as caring for your children or pets, household chores, etc.

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List the things that would not help or might worsen your symptoms:

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## Signature and Statement of Witness



**Your Signature:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

Witness Statement: I affirm that the individual who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed this document in my presence:

**Witness 1** (must be 18 years of age or older)

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

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**Witness 2** (must be 18 years of age or older)

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

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**Signature of Notary Public** (if notarized)

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Notary Public Stamp:**