Aftercare Plan

Full Name: _____

Date of Birth: _____

Date of Discharge: _____

Clinician: _____

AFTERCARE PLAN TREATMENT GOALS

Short-Term Goals: _____

Long-Term Goals: _____

Duration of Symptoms

ONGOING TREATMENT THERAPY SESSIONS:

Therapist: _____

Frequency: _____

Contact Information: _____

ONGOING TREATMENT SUPPORT GROUPS:

Group Name: _____

Meeting Times: _____

Contact Information: _____

MEDICATION MANAGEMENT MEDICATIONS PRESCRIBED:

Medication: _____

Dosage: _____

Instructions: _____

Pharmacy Name: _____

Phone Number: _____

Aftercare Plan Continued

CRISIS MANAGEMENT EMERGENCY CONTACTS:

Primary Contact: _____

Relationship: _____

Phone Number: _____

CRISIS MANAGEMENT HOTLINES:

National Suicide Prevention Lifeline: 1-800-273-8255

Substance Abuse Hotline: 1-800-662-HELP (4357)

Contact Information: _____

CRISIS MANAGEMENT CRISIS PLAN:

Steps to take in a crisis: _____

LIFESTYLE AND WELLNESS: HEALTHY LIFESTYLE CHOICES:

Nutrition: _____

Exercise: _____

Sleep Hygiene: _____

LIFESTYLE AND WELLNESS WELLNESS ACTIVITIES:

Activity: _____

Frequency: _____

SUPPORT SYSTEM KEY SUPPORT PERSONS:

Name: _____

Relationship: _____

Contact Information: _____

Aftercare Plan Continued

LEGAL AND FINANCIAL SUPPORT
LEGAL ASSISTANCE:

Attorney: _____

Contact Information: _____

LEGAL AND FINANCIAL SUPPORT
FINANCIAL ASSISTANCE:

Program: _____

Contact Information: _____

FOLLOW-UP APPOINTMENTS
PRIMARY CARE PROVIDER:

Name: _____

Date/Time: _____

Contact Information: _____

FOLLOW-UP APPOINTMENTS
SPECIALIST APPOINTMENTS:

Specialist: _____

Date/Time: _____

Contact Information: _____

Client Agreement:

I, _____, agree to follow this aftercare plan to the best of my ability to support my ongoing recovery and well-being.

Client Signature: _____

Date: _____

Clinician Signature: _____

Date: _____