Wellness Recovery Action Plan
(WRAP)

Name: _______________________  Date: _______________

Wellness Toolbox

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What I'm Like When I'm Feeling Well
Daily Maintenance List
Things to Consider Doing Each Day to Relieve Stress and Maintain My Wellness/Recovery
Triggers
Triggers Action Plan
Early Warning Signs
Feeling Much Worse
Action Plan for Helping Myself to Feel Better When I am Feeling Much Worse
Crisis Plan

What I'm Like When I'm Feeling Well.

I need help when I:
Supporters

Name _____________________________________
Address  ___________________________________________________________
Phone Number ______________________________________________________
Area of expertise or specific task I would like them to take care of

Name _____________________________________
Address  ___________________________________________________________
Phone Number ______________________________________________________
Area of expertise or specific task I would like them to take care of

Name _____________________________________
Address  ___________________________________________________________
Phone Number ______________________________________________________
Area of expertise or specific task I would like them to take care of

Name _____________________________________
Address  ___________________________________________________________
Phone Number ______________________________________________________
Area of expertise or specific task I would like them to take care of
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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<th>Area of expertise or specific task I would like them to take care of</th>
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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>Why I do not want them involved (optional)</th>
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Also, list those people you want your supporters to notify if you are in a crisis, such as your employer or family members--along with what to tell each of them.

**People to Notify**

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<th>Please notify</th>
<th>Tell them</th>
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How I want disputes between my supporters settled
Medical Information/Medications / Supplements / Health Care Preparations

Physician
Name _________________________ Phone number _________________________

Psychiatrist
Name _________________________ Phone number _________________________

Other Health Care Providers
Name _________________________ Phone number _________________________
Area of expertise ________________________________

Name _________________________ Phone number _________________________
Area of expertise ________________________________

Name _________________________ Phone number _________________________
Area of expertise ________________________________

Pharmacy _________________________ Phone number _________________________

Allergies

Insurance numbers and other insurance information
Medication / Supplement / Health Care Preparations

Name ____________________________ Dosage ____________________________
Purpose

Name ____________________________ Dosage ____________________________
Purpose

Name ____________________________ Dosage ____________________________
Purpose

Name ____________________________ Dosage ____________________________
Purpose

Name ____________________________ Dosage ____________________________
Purpose

Name ____________________________ Dosage ____________________________
Purpose
Medication / Supplement / Health Care Preparation to be used if needed

Name ________________________ Dosage _________________
When to use  ______________________________________________

Name ________________________ Dosage _________________
When to use  ______________________________________________

Name ________________________ Dosage _________________
When to use  ______________________________________________

Name ________________________ Dosage _________________
When to use  ______________________________________________

Name ________________________ Dosage _________________
When to use  ______________________________________________

** Medications / Supplements / Health Care Preparations to avoid

Name  ________________________________________
Should be avoided because  ____________________________________________

Name  ________________________________________
Should be avoided because  ____________________________________________

Name  ________________________________________
Should be avoided because  ____________________________________________

Name  ________________________________________
Should be avoided because  ____________________________________________

Name  ________________________________________
Should be avoided because  ____________________________________________

**take special note
Treatments and Complementary Therapies

**Treatment/Complementary Therapy**

Name _______________________
When and how to arrange for use

Name _______________________
When and how to arrange for use

Name _______________________
When and how to arrange for use

Name _______________________
When and how to arrange for use

Name _______________________
When and how to arrange for use

Name _______________________
When and how to arrange for use

Name _______________________
When and how to arrange for use
Home/Community Care/Respite Center

If possible, help me use the following care plan:
Hospital or other Treatment Facilities

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

Name ______________________________________
Contact Person ______________________________
Phone Number ______________________________
I prefer this facility because

Name ______________________________________
Contact Person ______________________________
Phone Number ______________________________
I prefer this facility because

Name ______________________________________
Contact Person ______________________________
Phone Number ______________________________
I prefer this facility because

Name ______________________________________
Contact Person ______________________________
Phone Number ______________________________
I prefer this facility because
### Avoid using the following hospital or treatment facilities

<table>
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<th>Name</th>
<th>Reason to avoid using</th>
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### Help From Others

Please do the following things that would help reduce my symptoms, make me more comfortable and keep me safe.
I need (name the person) _______________________ to (task)  
__________________________________________________________

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

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

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

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

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

Do not do the following. It won’t help and it may even make things worse.
When My Supporters No Longer Need to Use This Plan

The following signs, lack of symptoms or actions indicate that my supporters no longer need to use this plan.

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 ____________________