Child Revision Date: 07.16.2022

PATIENT NAME: ______________________________

DOB: ______________________________

Relapse Prevention Plan / My Safety Crisis Plan

Recognize your warning signs and use your coping skills to keep yourself safe and healthy

Triggers and Stressors

(Behaviors, situations and circumstances that put you at emotional risk)

____

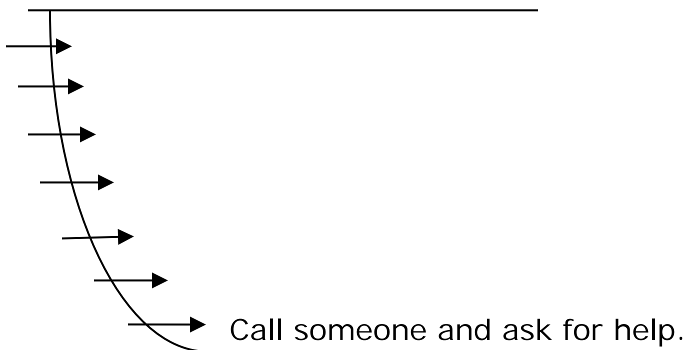
____

____

____

Warning Signs

(Your behaviors signals that show you're growing more and more at risk)



Warning Signs to Always Ask for Help with:

- Thoughts that you might be better off dead
- Thoughts about hurting yourself or someone else
- Making a plan to hurt yourself or someone else

My Coping Skills…

What I can do to be calm and stay safe IN THE MOMENT:

What can my support person do to help me?

Child Revision Date: 07.16.2022

PATIENT NAME: ______________________________

DOB: ______________________________

My goals for healthy behavior (reasons to keep myself safe):

1.

2.

3.

People to call if I am concerned about suicidal thoughts and/or having difficulty using my coping skills:

-
-
- Call my therapist, ____________________________. I can reach them at: _________________________. My follow-up appointment is on: ______________.
- Call my psychiatrist, ________________________. I can reach them at: _________________________. My follow-up appointment is on: ______________.
- **Suicide Crisis LifeLine** - Text or Dial: **988**
- SLBMI after hours exchange: 314-534-0200
- Text **HOME** to 741741 (www.crisistextline.org)
- *www.988lifeline.org*
- Behavioral Health Response Youth Connection Hotline: 1-844-985-8282 or text BHEARD to 31658
- 911

Reminders

- Take medications as ordered – do not change the dose or time unless directed by your physician.
- If you experience side effects from your medications – notify your outpatient provider or PCP
- For Children/Adolescents – Medication should be kept out of reach and in a secure place
- Keep all aftercare appointments as scheduled – take your copy of aftercare plan to your appointment

_______ *(initial)* I do not have access to prescription medication (for use other than prescribed) nor do I have access to lethal/illicit medications

_______ *(initial)* I do not have access to weapons nor do I have access to other means of self-harm.

_______*(initial)* I attest that the above information is complete and accurate.

Patient: ___________________________________ Date:_____________
(signature)

Parent/Guardian ___________________________________ Date:_____________
(signature)

Support Person Relationship to Patient:___________________________

Clinician: ___________________________________ Date: _____________
(signature)

Patient received copy Parent/Guardian received copy Copy placed in chart

Reviewed & updated Safety Plan on the following dates with the patient (initial and date):