

Relapse Prevention Plan

Patient Name: _____ Consumer # _____ Today's Date: _____

Contact/ Appointment Information

Primary Care Clinician: _____ Tel. No.: _____

Next appointment: *Date:* _____ *Time:* _____

Depression Clinical Specialist: _____ Tel. No.: _____

Next appointment: *Date:* _____ *Time:* _____

Maintenance Antidepressant Medications

1. _____ : _____ tablet(s) of _____ mg _____ Take at least until _____

2. _____ : _____ tablet(s) of _____ mg _____ Take at least until _____

3. _____ : _____ tablet(s) of _____ mg _____ Take at least until _____

4. _____ : _____ tablet(s) of _____ mg _____ Take at least until _____

Call your primary care provider or your depression clinical specialist with any questions (See contact information above)

Other Treatments:

1. _____

2. _____

3. _____

How to Minimize Stress from Depression

1. _____

2. _____

3. _____

4. _____

5. _____

Personal Warning Signs

1. _____

2. _____

3. _____

4. _____

5. _____

If symptoms return, contact _____