Plan last updated on: \_\_\_\_\_\_

**Wellness and Protection Plan**

**Name: D.O.B**

**Address: Phone:**

**My team:**

* Therapist: Phone:
* Case manager: Phone:
* Parenting: Phone:
* Child Welfare Worker: Phone:
* RSC/CCS/TCM: Phone:
* Psychiatrist: Phone:
* Primary Care Physician: Phone:
* Emergency contact: Phone:

Relationship:

**If a lapse occurs I will call on-call at (414) 840-8101 to invoke the Emergency Safety Plan. I must speak with staff to determine when it is safe for me to return to the Recovery Community.**

I will go with: Phone:

To address:

My child(ren) will go with: Phone:

To address:

* First Step Detox 2835 N 32nd St, Milwaukee, WI 53210

Phone: (414) 342-6200

* Columbia St Mary’s 2301 N. Lake Drive, Suite 1407, Milwaukee, WI 53211

Phone: (414) 585-1163

* Froedtert Hospital 9200 W Wisconsin Ave, Milwaukee, WI 53226

Phone: (414) 805-3000

* Wheaton Franciscan Healthcare - St. Francis 3237 S 16th St, Milwaukee, WI 53215 Phone: (414) 647-5000

I can return to the Meta House housing community at the time determined by on-call or my team.

My child(ren) will return when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Meta House and\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will be informed the next business day and my team will schedule an emergency team meeting.

**In the event of an unplanned discharge and I need to leave the Recovery Community by 3pm I will go to the following place. If my identified location(s) is no longer an option, I understand I will need to call for shelter. If shelter is not available, I understand I will still be discharged by 3pm.**

Option 1: I will go with: Phone:

To address:

Option 2: I will go with: Phone:

To address:

My child(ren) will go with: Phone:

To address:

**My medications:**

Prescribing Physician:

**My medications are located in my individual safe**:

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Possible Side Effects** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**My allergies/Special Needs:**

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***MY CHILD(REN)***

Name(s) and DOB

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If an emergency were to happen to me, my child(ren) will go to with:**

Name:

Address:

Phone:

**Safe people for my child(ren) to spend time with if I am overwhelmed:**

* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s Name:**

School/Daycare**:**

Address:

Phone:

**Child’s Name:**

School/Daycare**:**

Address:

Phone:

**Child(ren)’s Pediatrician:**

Address:

Phone:

After-hours number:

**Child(ren)’s Medications:**

**Name of Child**:

**My child’s medications are located in my individual safe:**

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Possible Side Effects** |
|  |  |  |
|  |  |  |
|  |  |  |

**Child’s Allergies/Special Needs:**

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Child**:

**My child’s medications are located in my individual safe:**

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Possible Side Effects** |
|  |  |  |
|  |  |  |
|  |  |  |

**Child’s Allergies/Special Needs:**

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_