



Capital Health

Mental Health Program

Wellness Plan

Name: _____

Address: _____

City/Town: _____

Postal Code: _____

Phone: _____

Date of Birth: (YYYY/MM/DD) _____

Health Card #: _____

Health Unit #: _____

Primary Language: _____

Cultural Needs: _____

Spiritual Needs: _____

Number of Dependant(s) under my Care: _____

Name	Age	Relationship

Living Situation:

- On Own Group Home Small Options
 With Family Licensed Boarding Home Shelter
 Supported Apt. Hospital Other _____

Psychiatric Diagnosis(es):	Allergies/Reactions:
Physical Diagnosis(es):	Other Health Concerns:



Kardex/Care Plans

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Key Contacts		
Primary Mental Health Worker (Capital Health): _____ Service /Agency: _____		
Address: _____		
_____ Phone #: _____		
Psychiatrist: _____ Service /Agency: _____		
Address: _____		
_____ Phone #: _____		
Family Doctor: _____ Service /Agency: _____		
Address: _____		
_____ Phone #: _____		
Emergency Contact: _____ Relationship: _____		
Address: _____		
_____ Phone #: _____		
Next of Kin: _____ Relationship: _____		
Address: _____		
_____ Phone #: _____		
Housing Support Worker: _____ Service/Agency: _____		
Address: _____		
_____ Phone #: _____		
Income Source(s):		
Service/Agency/Employer:	Key Contact:	Phone #:
_____	_____	_____
_____	_____	_____
_____	_____	_____
Peer Support Contact(s):		
Formal/Informal:	Relationship:	Phone #:
_____	_____	_____
_____	_____	_____
Other Contact: _____ Relationship: _____		
Address: _____		
_____ Phone #: _____		

Medication Arrangements:

Doctor ordering Psychiatric Meds:	Doctor ordering Medical Meds:	Pharmacy (Name/Address/Phone #):
<input type="checkbox"/> Pick up Meds at Pharmacy <input type="checkbox"/> Delivery of Meds at Home	Injection: <input type="checkbox"/> No <input type="checkbox"/> Yes, frequency: _____	If Injection (When/Where/By Whom):

Assistance required in my daily routine,
e.g., medications, meals, self-care, mobility:

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Type of Assistance Needed:	Who Helps Me?	When/How Often?

1. What do I and/or others do to help me stay well mentally? _____

2. What are the early signs that I am becoming unwell? _____

3. What do I and/or others need to do if I experience these early signs? _____

4. What are the stressors/situations in my life that may cause me to become unwell? _____

5. What do I and/or others need to do if I get into these situations? _____

6. If I need to go in hospital, whom do I want to come with me? (List name, relationship, phone #.) _____

