LifeStance HEALTH

SUBSTANCE USE DISORDER PROGRAM RELAPSE PREVENTION PLAN

NAME: ___________________________

Number of days of continuous recovery: ___________________________

Identified triggers to use:

____
____
____

Intervention for the trigger:

____
____
____

Names and phone numbers of people I can call 24/7:

1. **Name:** ___________________________ **Phone:** ___________________________
2. **Name:** ___________________________ **Phone:** ___________________________
3. **Name:** ___________________________ **Phone:** ___________________________
4. **Name:** ___________________________ **Phone:** ___________________________
5. **Name:** ___________________________ **Phone:** ___________________________
6. **Name:** ___________________________ **Phone:** ___________________________

Number of meetings I am committed to attend each week: ___________________________

Location of those meetings:

____
____
____

What I will lose if I return to substance use:

____
____
____

Healthy lifestyle changes I am committed to making:

____
____
____

Situations in which I am most likely to use:

____
____
____

Steps I will take to avoid these situations:

____
____
____

Return to recovery plan if I do use:

____
____
____

Unresolved issues:

____
____
____

Referrals I have been given to address these issues:

____
____
____

Date: ___________________________

Patient Signature: ___________________________