ROSARY HALL - DISCHARGE/CONTINUING CARE TREATMENT PLAN

Patient's Name: ______________________________ **Phone:** ____________

To maintain sobriety and to continue to heal physically, mentally, socially and spiritually, I will follow these specific guidelines.

1. I will abstain from alcohol and all mood-altering drugs.
2. **SUPPORT GROUP (AA, NA, CA) meetings** I plan to attend every week:

   Sun. ______________________________

   Mon. ______________________________

   Tues. ______________________________

   Wed. ______________________________

   Thurs. ______________________________

   Fri. ______________________________

   Sat. ______________________________

3. **DAILY PLAN:** My daily plan to insure sobriety:

   ____

   ____

   ____

   ____

4. **PLAN TO DEAL WITH DESIRE TO USE:** including people and places I must avoid to stay alcohol and drug free.

   ____

   ____

   ____

5. **BEHAVIORAL/ATTITUDE** changes I need to make to maintain sobriety:

   ____

   ____

ST. VINCENT CHARITY
MEDICAL CENTER

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CLEVELAND, OH 44115
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A Ministry of the Sisters of Charity Health System

PATIENT LABEL

SVPOD-104 (REV. 3/05)

6. **RELAPSE:** Three signs that would most likely lead to my relapse:

____

____

____

To help prevent a possible relapse, I agree to discuss these signs openly and honestly with the following persons:

Name	Relationship
______________________	______________________
______________________	______________________
______________________	______________________

If any of the above persons notice any of the signs indicated above, I want them to take the folowing action:

____

____

____

7. **AFTERCARE GROUP:** I will attend aftercare at Rosary Hall at ____________ (time) on ______________ (day)

beginning on ______________ (date) for ______________ weeks.

My Aftercare Counselor will be ______________________________

PROBLEMS/CONCERNS I need to work on in Aftercare are: ______________________

____

____

____

8. **OTHER TREATMENT NEEDS/REFERRALS** (e.g., language/learning problems, assistance with Activities of Daily Living, etc.): specify needs, referrals made, contact person and appointment time):

____

____

____

______ I have been given a copy of this plan. (Initial)

______________________	______________________
Patient's Signature	Counselor/Witness
______________________	______________________
Date	Date