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:

_____
_____
_____

Return to recovery plan if I do use:

_____
_____
_____

Situations in which I am most likely to use:

_____
_____
_____

Unresolved issues:

_____
_____
_____

Steps I will take to avoid these situations:

_____
_____
_____

Referrals I have been given to address these issues:

_____
_____
_____

Date: _____

Patient Signature: _____