MASSACHUSETTS GENERAL HOSPITAL
HOPE CLINIC

MassGeneral Hospital for Children℠

RECOVERY PORTFOLIO

my information, my relapse prevention plan, my plan of safe care

MY NAME _____ **DOB** _____

Phone Number _____

Street Address _____ City/Town _____ State _____ Zip _____

Due Date: _____

IN CASE OF EMERGENCY CONTACT

Name: _____

Phone Number: _____

Address: _____ State: _____ Zip Code: _____

[ ] Release signed

Other Children:

Name: _____ DOB: _____ Living with: _____

Name: _____ DOB: _____ Living with: _____

Name: _____ DOB: _____ Living with: _____

Name: _____ DOB: _____ Living with: _____

In Case of Emergency, who would you want to take care of your child(ren)?

Name_____ Phone Number _____

Relationship to you and/or your child _____

DELIVERY PLAN

Delivery Hospital: **Mass General Hospital, Blake 14**

OB Provider Emergency Line #: **617-724-2229**

MY TEAM

Role on team *(Type of Provider?)*	**Agency** *(Or relationship)*	**Name**	**Phone #**	**Other contact information** *(e.g. email, best time to call, etc.)*
Primary Care Doctor				
Prenatal Care Provider				
Pediatrician				
Psychiatrist				
Social Worker				
Therapist				
MAT Provider				
SUD Treatment Provider				
Recovery Coach				
DCF Case Worker				
Early Intervention				
Sponsor				
Probation Officer				
Case Manager				

My medications:

My Resources

Resources	Established	Need support	Comments
Housing			
Financial (DTA, TANF)			
Food (SNAP)			
Employment			
Transportation			
Items for child (car seat, diapers and wipes, furniture, clothing, etc)			
WIC			
Breastfeeding			
VNA services (postpartum)			
Childcare			
Faith or Cultural Support			
Parent support groups			
Other identified needs:			

Strengths Based
Relapse Prevention Plan

Awareness: Warning signs that I might use (physical, cognitive, behavioral)

_____

_____

_____

_____

_____

_____

Support: People who I can call to help me get through a craving

1. _____
2. _____
3. _____
4. _____
5. _____

Coping Skills: Activities or skills I can enjoy to get my mind off of using

_____

_____

_____

_____

_____

Benefits of being sober:

_____

_____

_____

_____

_____

How my life would change if I used:

_____

_____

_____

_____

_____

If I use/drink, these are the steps that will get me back on track:

_____

_____

_____

_____

_____

How I will keep my child(ren) safe if I use:

_____

_____

_____

_____

_____

How I will keep myself safe if I use:

_____

_____

_____

_____

_____

Patient Signature:

Support Team Signature:

Date: