# Mental Health Care Plan

FIRECLAY HEALTH
Your Health is Our Concern

Thank you for filling in this questionnaire. This information will help us to look after you better.

| **Name:** | **Date of Assessment:** |
|---|---|

| **People involved in your care (e.g. family, carer, GP, CPN, psychiatrist)** | | |
|---|---|---|
| **Name** | **Phone No** | **What do they do for you?** |
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| **Crisis and Contingency Plan** | |
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| What are the early warning signs that could mean things are going wrong? | |
| What are potential sources of stress for you? | |
| What things have helped in the past? | |
| If you experience warning signs, we have agreed that you will: | |
| The person to contact in a crisis is: *(name & telephone number)* | |

**Medication Review** Any problems or side effects? Any regular over-the-counter remedies (including herbal remedies) ?

| Your Needs and Care Plan |
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| What needs would you like to discuss? (e.g. physical or mental health, medication, social problems) |
| Carer's view of needs: (if known) |

| General Information | |
|---|---|
| **Factor** | **Possible needs** |
| **Daily Living and Home Management**<br>Self care, mobility, cooking, shopping, housework & laundry | |
| **Food and Nutrition**<br>Awareness of healthy eating, recent weight loss or gain, changes in eating habits, specific dietary needs, adequate fluid intake | |
| **Accommodation** | |
| **Employment Status**<br>Paid and unpaid work, training and education, Work related problems | |
| **Leisure and Recreation** | |
| **Cultural and Faith Needs** | |
| **Independence and Social Contact** | |
| **Financial Circumstances**<br>Benefits received, financial advice needed | |

| **Action Plan:** |
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I agree that this is an accurate summary of my needs.

Signed: Date: