Worldwide Autists

Independent Support Plan **Date:**

Name	
Date of birth	
Ethnicity	
Address	
Country of residence	
Telephone	
Email	
Name of your doctor	
Address for your doctor **Telephone**	
Name of your Next of Kin **Address** **Telephone** **Relationship to you**	

This is your Independent Support Plan. You may want to share it or have it somewhere in your home or workplace where you can refer to it or be accessed by a trusted associate. What works best for you is your decision.

My Care and Support Plan	
About me	
Personal and family background	
Areas of my life I enjoy or value the most	
Changes that would improve my wellbeing or quality of life	

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My medication	
Are you currently taking prescribed medication?	

Identified areas of risk in your personal life and how they can be managed	

Managing situations that may cause concern	
An emergency or crisis occurs	
What action will be taken?	**What should I do?**
In the event of ill health, injury or suicidal thoughts	Call your physician or emergency department
In the event of decline in mental health, loneliness or feelings of despair or meltdown from distressing triggers	Go for a walk Sit and lie down Write down your thoughts on paper Put your phone or laptop away Find a calm, quiet place Send a message to a friend