COMPLETION PLAN
FOR RELAPSE PREVENTION

DAWN
Depression Attention for Women Now

Patient Name: _____ **Date:** _____

Contact Information:

OB-GYN Provider: _____ Phone: _____

Provider(s) who will help you in the future:

1. _____ Phone _____ Next Appt: _____
2. _____ Phone _____ Next Appt: _____

Maintenance Antidepressant Medications

1. _____ _____ tablet(s) of _____ mg ___ times/day Take at least until _____
2. _____ _____ tablet(s) of _____ mg ___ times/day Take at least until _____
3. _____ _____ tablet(s) of _____ mg ___ times/day Take at least until _____
4. _____ _____ tablet(s) of _____ mg ___ times/day Take at least until _____

Call your primary care provider or your depression care manager with questions. (See contact information above)

Depression Treatment Completed During the Study

1. _____ From: _____ To: _____
2. _____ From: _____ To: _____
3. _____ From: _____ To: _____

How to Minimize Stress from Depression

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

Personal Warning Signs

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

If symptoms return, contact:

_____