

**MACOMB COUNTY COMMUNITY MENTAL HEALTH
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE
BTPRC ACTION**

CONSUMER NAME: _____

CASE NO: _____

PRESENTED BY: _____

DATE OF THIS REPORT: _____

1. TYPE OF REVIEW: Initial Review Consultation Discontinuation

2. **REASON REVIEW REQUIRED:**

(Check the intervention(s) used. Use two x's "[xx]" for the one most prominent).

Programmatic Restriction

Restrictive-Communication (e.g., Telephone, Internet & Mail limitations, etc.)

Restrictive-Food (e.g., Locked food cabinets, Locked refrigerator, etc.)

Restrictive-Freedom of movement (e.g., Wander guard, Wheelchair seat belt guard for behavioral control, Bedrail, etc.)

Restrictive-Other limits to rights (e.g., Locked Cabinets/Doors, Loss of Privilege, Property Search, Protective Clothing, etc.)

Intrusive- Encroach upon personal space (e.g., unwelcome intense supervision, etc.)

Medication - Intrusive for behavioral control (e.g., multiple psychotropic medications, especially antipsychotics)

Protective Device - Intrusive-Encroach upon bodily integrity (e.g., A device strapped directly to the body (elbow) to reduce mobility in order to control behaviors (Severe SIB)—and the individual cannot independently remove it.)

Emergency Physical Intervention (e.g., Standing Hugs or Brief Physical holds in response to severe SIB or Aggression)

Emergency Law Enforcement (e.g., Assistance from police)

EMERGENCY PHYSICAL MANAGEMENT

Other: _____

3. BTPRC ACTION: APPROVED PARTIAL APPROVAL CONDITIONALLY APPROVED DISAPPROVED DISCONTINUED

Specific Interventions Requested: _____

4. Rationale for BTPRC decision: _____

5. Actions needed based on BTPRC decision: _____

6. Items NOT Approved: _____

7. Date for next review by BTPRC: _____

8. Special Consent Form: Needs to be signed/updated Behavior Treatment Plan: Needs revisions and bring copy to next review

9. BTPRC Signatures: *(Signature /Credentials/Date)*
