*MACOMB COUNTY COMMUNITY MENTAL HEALTH*

**Behavior Treatment Plan Review Committee**

Initial Presentation Worksheet

**DATE**:
**NAME**:
**PRESENTER(S)**:
**PRESCRIBING PHYSICIAN**:
**DATE OF BIRTH:**

**HOME TYPE**:
**AGENCY**:
**CASE NUMBER**:
**SUPPORTS COORD/CASE MANAGER**:
**WAIVER TYPE: [ ]** None **[ ]** CWP**[ ]** HSW (Hab)**[ ]** SEDW

**TYPE OF REVIEW:***(Check all that apply. Use two x's "[xx]" for the one most prominent).*

[ ] **Initial** [ ]**Review** [ ]**Consultation**

**ISSUE BEING REVIEWED:***(Check all that apply. Use two x's "[xx]" for the one most prominent)*

[ ] **HS** Harm to Self
[ ] **HO** Harm to Others
[ ] **PD** Property Destruction
[ ] **EMPM** Emergency use of Physical Management
[ ] **EMLE** Emergency use of Law Enforcement

Has a positive behavior support plan been developed and implemented? [ ] Yes [ ] No

**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 & Mai 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:

| **SPECIFIC RESTRICTION, INTERVENTION OR DEVICE**: | START DATE | MONITORING DOCUMENT | END DATE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**DIAGNOSTIC AND TESTING INFORMATION (DSM 5 Diagnoses and codes)**

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**(I.Q. scores optional)**

**F.S.I.Q. =** __________ **V =** __________ **P =** __________ **DATE:** __________

**BRIEF DESCRIPTION OF PERSON**:

**DEFINITION OF PROBLEM / PROBLEM STATEMENT:** *(attach additional documents as needed)*

**A. Describe the behavior(s) displayed that warrant and justify medication and/or behavior intervention. Describe and define in observable and, if possible, measurable terms. If this is a review of a behavior treatment plan, please provide plan status.**

**B. If this is an initial behavior treatment plan, describe the age of onset and the circumstances surrounding the onset of the behavior:**

**Behavior Treatment Plan Summary**:

**A. Functional Behavioral Assessment Date:** ______________________________

**B.**

**I. Has a trauma screening been completed? _____ YES _____ NO**
**II. Has trauma been identified? _____ YES _____ NO (If yes, proceed to question III. and IV).**
**III. If trauma is identified, is there a completed trauma assessment. _____ YES _____ NO**
**IV. If trauma is identified, is it addressed in the current Behavior Treatment Plan? _____ YES _____ NO**

**C. Treatment GOAL:**

**D. Positive/Proactive TREATMENT Strategies & Supports:**

**E. Nature and Description of CAREGIVER TRAINING by behaviorist AND frequency of training:**

**MEDICATIONS** (*LIST CURRENT MEDICATION(S) AND DOSAGE(S); DESCRIBE ANY PRE-EXISTING PHYSICAL CONDITIONS AND SYMPTOMS THAT MAY HAVE SOME INFLUENCE ON TARGET BEHAVIOR*)

1.
2.
3.
4.
5.

Number of antipsychotics: _____ Number of psychotropic(s): _____

Medical conditions/diagnosis:

______________________________________________________________________________________________

Have physical, medical & environmental causes been ruled out? [ ] Yes [ ] No How? ______________________________________________

List Pertinent Labs:

______________________________________________________________________________________________

**PLAN FOR ELIMINATION OF RESTRICTIVE/INTRUSIVE INTERVENTION**:

***ATTACH A COPY OF CURRENT FUNCTIONAL ASSESSMENT, BEHAVIOR PLAN, AND DATA SHEETS.***
***PLAN WILL NOT BE REVIEWED WITHOUT DOCUMENTATION.***