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. If trauma is identified, is there a completed trauma assessment. _____ YES _____ NO
III. 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.