

MACOMB COUNTY COMMUNITY MENTAL HEALTH  
Behavior Treatment Plan Review Committee  
Ongoing Presentation Worksheet

DATE: HOME TYPE:  
NAME: AGENCY:  
PRESENTER(S): CASE NUMBER:  
PRESCRIBING PHYSICIAN: SUPPORTS COORD/CASE MANAGER:  
DATE OF BIRTH: WAIVER TYPE: [ ] None [ ] CWP [ ] HSW (Hab) [ ] SEDW

Please complete this worksheet with updated information since last review.

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

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

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 & 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:

BRIEF DESCRIPTION OF PERSON: (Age, living arrangement, etc.)

DIAGNOSTIC INFORMATION: (Diagnosis, mental health, medical, etc)

BEHAVIOR PLAN SUMMARY AND POSITIVE BEHAVIOR SUPPORTS:

MEDICATIONS: Number of Antipsychotics: \_\_\_\_\_ Number of Psychotropics: \_\_\_\_\_

List Medications:

- 1.
- 2.
- 3.
- 4.
- 5.

UPDATES SINCE LAST REVIEW:

PLAN FOR ELIMINATING RESTRICTIVE/INTRUSIVE INTERVENTION(S):

HAS THE BEHAVIOR PLAN BEEN REVISED? IF SO, WHAT ARE THE REVISIONS? (Attach copy of revised plan).

SINCE LAST REVIEW HAVE THERE BEEN INCIDENTS OF:

Harm to Self? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_

Harm to Others? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_

Emergency physical Management? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_

911 calls? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_