Request for Program Review Committee (PRC) Date to Review

## Behavior Modifying Medication or Aversive or Restraint Procedures

**TO: PROGRAM REVIEW COMMITTEE (PRC) REGION:**

**FROM: Name**

**Address**

**Agency/Facility Name**

**Phone #**       **Fax #**

**Email Address**

**DATE:**

**PRC CONTACT/DDS CASE MANAGER TO COMPLETE BOXES BELOW**

|  |  |  |
| --- | --- | --- |
| **Last Review Date** | **Prescriber’s Name** | |
| **Name** | **DDS #** | |
| **Address**  **Agency/Facility Name**  **Reason for Request:**  **Medication**  **New**  **Dose Change** **Range Change**  **Aversive Procedure**  **Restraint**  **Noxious** **Other** | | |
| **Medication Name, Dose & Range (if appropriate):** | | **Start Date:** |
| **1.** | |  |
| **2.** | |  |
| **3.** | |  |
| **4.** | |  |
| **Restraint Procedure: Describe** | | |
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **Aversive Procedure: Describe** | | |
| **1.** | | |
| **2.** | | |
| **3.** | | |

**PRC TO COMPLETE BOX BELOW**

|  |
| --- |
| **REVIEW TYPE:** **Presentation**  **Paper Review**  **Comprehensive PRC Presentation Not Required At This Time (NOTE:** If ‘Comprehensive PRC Presentation Not Required’ is ‘checked’ then the Planning & Support Team (PST) does not need to return to the PRC unless there is a change in diagnosis, significant change in medication type, significant change in medication dosage exceeding the FDA range, or a significant increase in problem behaviors related to the use of medication. Date ‘Faxed/Send…’ will serve as proof that PST complied with PRC Procedures.)  **PRC Scheduled Date :** **/****/****Date Faxed/Sent to Agency/Facility:** **/****/**  **Materials Due Date:** **/****/****Completed Packet Received Date:** **/****/** |