|  |  |  |  |
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| **ICF/IID REQUEST FOR PROGRAM REVIEW COMMITTEE INTERIM APPROVAL** | | | |
| **Date of Request      /     /** | | | |
| Name: | DDS # | | DOB:      /     / |
| Residence: | | Agency: | |
| Case Manager/Contact Person: | | | |
| Email Address (To email approval):       Fax # (To fax approval): | | | |

|  |  |
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| **DSM-5, or current edition, Diagnosis** | |
| **Clinical Disorders** |  |
| **Cognitive/Personality Disorders** |  |
| **General Medical Conditions** |  |
| **Prescriber:** | **Date last seen by Prescriber** |

|  |  |
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| **List Behaviors of Concern** | |
| **1.** | **4.** |
| **2.** | **5.** |
| **3.** | **6.** |

|  |  |
| --- | --- |
| **List Target Behaviors** | |
| **1.** | **4.** |
| **2.** | **5.** |
| **3.** | **6.** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **List all current medications;**  **List new medication/dose first** | | **Current**  **Dose** | **Proposed Range** | **Status: Check One** C = Current (Has PRC approval)A = Add (Needs PRC approval) | |
| **1.** |  |  |  | **C** | **A** |
| **2.** |  |  |  | **C** | **A** |
| **3.** |  |  |  | **C** | **A** |
| **4.** |  |  |  | **C** | **A** |
| **5.** |  |  |  | **C** | **A** |
| **6.** |  |  |  | **C** | **A** |

**Rationale for New Medication(s) or Dose Change(s):**

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### Individual or Guardian Consent Yes No

#### Interim Review/Approval

**PRC Psychiatrist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date** **/****/****Signature**

**PRC Liaison \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date** **/****/****Signature**

## Regional Director \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date      /     /      Signature

## Date Faxed to Agency:      /     /      Date for Full PRC Review:      /     /

**Date Material Due:** **/****/**