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**

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| --- | --- |
| **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**

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| **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:** **/****/** |