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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.**  |

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

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