St. Clair County Community Mental Health

Behavior Treatment Plan Review Committee

Referral

Recipient's Name:	**Case Number:**
Primary Program:	**Residential Facility Name:**
Secondary Program:	**Case Holder's Name:**
SECTION A: AUTHORIZATION	
Case Holder's Signature:	**Date:**
Program Supervisor's Approval/Signature:	**Date:**
Chief Clinical Officer's Approval/Signature:	**Date:**
SECTION B: TYPE OF REFERRAL	
□ **Aversive Technique** □ **Intrusive Technique** □ **Restrictive Technique** Description: _____ _____ _____ _____	□ **Lethal Case Review** Date of Death:
□ **Clinical Consultation** Background Information:	□ **Token Economy/Response Cost** Description of Plan:
SECTION C: REQUIRED MATERIALS FOR BTPRC REVIEW	
Aversive/Intrusive/Restrictive Techniques, Clinical Consultations, and Token Economy/Response Cost Reviews*:	**Lethal Case Review:** □ **Incident Report** (attach copy)

□ **Behavioral Assessment** (attach copy) □ **Clinical Assessment** (attach copy) □ **IPOS** (attach copy) **and Proposed Intervention** □ **Medication Review** (most recent; attach copy) □ **Psychiatric Evaluation** (most recent; attach copy)	□ **Death Report** (attach copy)