

Department of Mental Retardation
Human Rights Committee
Request for Review

Region: North South West

Individual's Name: _____ DMR #: _____ DOB: _____

Residence: _____ Provider: _____

Guardianship Status: _____ Name of Guardian: _____

Name, Title, and phone # of Person Submitting Request for Review: _____
Telephone #: _____

Case Manager: _____ Agency Contact person: _____

Request

Restrictive/Intrusive Program Alarms/Monitors Referred from PRC

Other _____

Human Rights Committee Recommendation

Date of Review: _____

Approved Disapproved Approved with Qualifications

Comments: _____

HRC Signatures: _____

HRC does not request further review

HRC requests periodic review in _____ months Presentation Paper Review

Regional Director Review

Approved Disapproved Approved with Qualifications

Comments: _____

Regional Director Signature: _____ Date: _____

Required forms:

HRC Information Sheet Applicable assessments and evaluations

Consents for all individuals impacted Applicable programs, baseline data, current graphs

Guardianship decree List of current diagnosis and medications

Applicable legal documents (i.e. probation/parole)