

# Unapproved Behavior Support Form

Individual's Name:

Date Form Filled Out:

Date of UBS:

MUI Number:

Name of Person filling out Form:

Title:

Agency:

Contact Information:

## UBS / HISTORY / ANTECEDENTS

Please list what led to UBS. Provide a timeline and whether this individual has a history of this behavior. Provide details of prevention measures from prior incidents.

How many times was the intervention used?  
How long (total) was the individual restrained?

## BEHAVIOR SUPPORT PLAN

Did the individual have a Behavior Support Program? Did the staff know about the BSP? Was the staff trained on the implementation of the BSP?

## INJURIES:

Were there any injuries to the individual or anyone else involved in the UBS? Did the individual receive timely medical attention?

**DESCRIPTION:**

Describe in detail the intervention and the reason used. How was it necessary for the health and welfare of individual or other individuals?

**CAUSE AND CONTRIBUTING FACTORS:**

- |  |   |
|--|---|
| <ul style="list-style-type: none"><li><input type="checkbox"/> <b>Supervision not met</b></li><li><input type="checkbox"/> <b>Staff ratio was not appropriate</b></li><li><input type="checkbox"/> <b>Diet not followed</b></li><li><input type="checkbox"/> <b>Asked to complete task</b></li><li><input type="checkbox"/> <b>Change in Routine</b></li><li><input type="checkbox"/> <b>Excessive Noise</b></li><li><input type="checkbox"/> <b>1:1 Attention unavailable</b></li><li><input type="checkbox"/> <b>Peer aggression</b></li></ul> | <ul style="list-style-type: none"><li><input type="checkbox"/> <b>Outing Cancelled</b></li><li><input type="checkbox"/> <b>Control Issues-staff/family/peers</b></li><li><input type="checkbox"/> <b>Medication Change</b></li><li><input type="checkbox"/> <b>Illness</b></li><li><input type="checkbox"/> <b>Possible Hallucination</b></li><li><input type="checkbox"/> <b>Loss of Important Relationship</b></li><li><input type="checkbox"/> <b>ISP/BSP Not followed</b></li></ul> |
|--|---|

**Other:**

**PREVENTION MEASURES:**

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li><input type="checkbox"/> <b>Physical/Social Environmental Change</b></li><li><input type="checkbox"/> <b>Agency Policy/System Change</b></li><li><input type="checkbox"/> <b>Staff Training</b></li><li><input type="checkbox"/> <b>Counseling</b></li><li><input type="checkbox"/> <b>Team Meeting to address ISP Changes</b></li><li><input type="checkbox"/> <b>Appointment with Medical Care Provider</b></li></ul> | <ul style="list-style-type: none"><li><input type="checkbox"/> <b>Medication Changes</b></li><li><input type="checkbox"/> <b>Follow up Appointment Scheduled</b></li><li><input type="checkbox"/> <b>PT/OT/Speech Referral made to address communication or mobility concern</b></li><li><input type="checkbox"/> <b>Diet Change Ordered</b></li><li><input type="checkbox"/> <b>Home Health Care</b></li></ul> |
|---|---|

**Other:**

**INVESTIGATIVE AGENT REVIEW:**

Comments & Questions:

**REVIEW COMPLETED DATE:**

**IA NAME:**

PLEASE CHECK ALL THAT APPLY

**Physical Restraint:**

- Baskethold**
- Multiple Person Carry**
- Multiple Person Escort**
- One Person Carry**
- One Person Escort**
- Other Restraint**
- Physically Prompted Hands down with resistance**
  
- Prone**
  
- Restraint of Multiple Appendages**
- Restrain or One Appendage**
- Seated Restraint**
- Side Restraint**
- Standing Restraint**
- Supine**
- Other:**
  
- Time-Out List details of time-out, including length of time**

**Chemical:**

- Anti-Anxiety**
- Anticonvulsant**
- Antidepressant**
- Antipsychotic**
- Mood Stabilizer**
- Other:**

**Mechanical:**

- Full Body-papoose board wrap**
- Full Body-seated position**
- Full Body-supine position**
- Gait Belt**
- Helmet**
- Locked Seat Belt/vest-not during transportation**
- Mitts**
- Others**
- Splints**
- Transportation-locked seatbelt/vest/others**
- Wheelchair controls disabled**
- Wheelchair for individual who does not use normally**
- Other**

