McLaren
NORTHERN MICHIGAN

Partial Hospitalization Program

Notice of Conference to Develop the Individual Plan of Service

Welcome to the McLaren Northern BHU Partial Hospitalization Program at the McLaren Cheboygan Campus. In addition to these forms, the psychiatrist and other members of the treatment team will complete assessments to assist in the development of an effective individual plan of service. The treatment team will begin working with patient on day of admission to develop the plan of service.

If patient would like an individual from their support system and/or their guardian(if applicable) to participate in the review and further development of their individual plan of service a meeting can be scheduled while patient is enrolled in the Partial Hospitalization Program. A review of the plan with the treatment team will be completed within 5 treatment days.

Philosophy regarding the use of restraint and/or seclusion

McLaren Northern Region Partial Hospitalization Program is committed to preventing, reducing, and striving to eliminate the use of restraints and seclusion. This includes attempting to prevent emergencies that have the potential to lead to using restraint or seclusion. Lesser restrictive, nonphysical measures must be attempted prior to using restraints and seclusion. Restraints and seclusion are not used in outpatient programs. Restrains or seclusion will only be used when there is a significant risk of a person harming self, others, or destroying property. Restraints or seclusion will be discontinued as soon as possible. Debriefing with staff and patient will occur after each episode of restraint or seclusion. The person's safety and dignity are of primary importance during the restraint or seclusion episode. In order to assist us in preventing an emergency that may lead to the use of restraints or seclusion, please help us by answering the following questions:

Please tell us any techniques and/or interventions you have found helpful in decreasing your anger or anxiety:

_____

_____

_____

Addressograph

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Please list any medical illnesses, physical disabilities, or history of physical or sexual abuse:

_____

_____

_____

☐ I have received a copy of this notice

☐ I wish to have the following family member or advocate involved in my treatment:

Name: _____ Relationship: _____

Contact Information: _____

Patient Signature: _____Date: _____ Time: _____

Parent/Guardian Signature: _____ Date: _____ Time: _____

Staff Signature: _____ Date: _____ Time: _____

Addressograph