

**Multi-Disciplinary Team Staffing
Participants and Outcome**

Child's Name: _____ Date of Staffing: _____

Level of care being considered: L1 L2 STGC Discharge

<p><u>MDT Decision & reason:</u></p> <p style="text-align: center;">Not Approved / Approved Level 1 / Approved Level 2 / STGC</p> <p>Reason: _____</p> <p>_____</p> <p>_____</p>
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Recommendations/Planned Services:

Attendee Signatures:
To fulfill our responsibility in maintaining client confidentiality, it is vital to guard against disclosing information in inappropriate situations. Therefore, all information discussed and disclosed in this meeting is to be held in the strictest of confidence.

MDT Team Committee Members: Please initial next to your name if you are in agreement with the MDT recommendation.

	Agree	Disagree
1. MDT Chair, BBCBC	_____	_____
2. Placement Representative	_____	_____
3. ACHA Representative	_____	_____
4. Case Manager	_____	_____
5. Provider	_____	_____

Other Attendees:

Name	Signature	Agency/ Position
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you disagree with the MDT recommendation, please sign below and explain why.
