

SECTION I – ALL RESTRAINTS (* = Required Field)

*(1) Individual: First Name:

Last Name:

*(2) Reporting Provider:

*(3) Area Office/ Facility:

*(4) Provider Location:

*(5) Order Date:

*(6) Type of Restraint Order: Initial Renewal Hold

*(7) Time of:

(7A) Initial Restraint:

(7B) Restraint Renewal:

(7C) Restraint Removal:

*(8) Name of Staff

Identifying Emergency:

(9) Position of Staff

Identifying Emergency:

*(10) Describe Emergency Situation:

*(11) Categorize Emergency Situation (check all that apply):

 Substantial Risk of Serious Physical Assault Occurrence of Serious Physical Assault Substantial Risk of Serious Self-Injurious Behavior Individual Placed Self at Imminent Risk
Of Significant Physical Harm Occurrence of Serious Self-Injurious Behavior

*(12) Describe the Individual's Behavior or Other Antecedents Before the Emergency Situation:

*(13) Describe Less Restrictive Methods Used Prior to Restraint:

(14) Did the Restraint Result in Physical Injury? YES NO(15) Was an Incident Report Filed? YES NO

of 6

Individual: First Name:

Last Name:

SECTION II – PHYSICAL RESTRAINTS – Complete only for Physical Restraints

*(P1) Describe How the Restraint Intervention was Implemented:

*(P2) Check the Position of Person Restrained During Restraint (check all that apply):

- Standing Standing and against wall/mat Sitting Lying Supine (on Back)
- Lying on Side Lying Prone (on Stomach) Escort Other, (describe):

*(P3) Was Mechanical or Chemical Restraint Also Used? No Yes

If Yes: Type: Time:

*(P4) Has Plan to Respond to This Emergency Behavior Been Developed in ISP? No Yes

If Yes, was it followed? Yes No (If not followed, explain why not):

*(P5) Describe Person’s Behavior and Condition During Restraint and Safety Checks:

*(P6) Reason for Permanent Removal of Restraint:

*(P7) Describe Behavior and Give Indicators of Individual’s Condition After Restraint:

*(P8) Print Names of Involved Parties:

(P8A) Authorizing Initial Restraint/Renewal:

(P8B) Applying Restraint:

	1.
	2.
	3.
	4.

(P8C) Specially Trained Monitor:

(P8D) Authorizing Removal:

of 6

Individual: First Name:

Last Name:

SECTION II – MECHANICAL RESTRAINT - Complete only for Mechanical Restraints

*(M1) Was Physical or Chemical Restraint Also Used? YES NO

If Yes: Type: Time:

*(M2) Type of Mechanical Restraint Used (Mitts only in the community absent a waiver from the DDS Office for Human Rights):

*(M3) Print Names of Involved Parties:

(M3A) Authorizing Initial Restraint/Renewal:

(M3B) Applying Restraint:

1.
2.
3.
4.

(M3C) Specially Trained Monitor:

(M3D) Authorizing Removal:

*(M4) Has Plan to Respond to Behavior Been Developed in ISP? YES NO

If Yes, Was the Plan Followed? YES NO If No, Explain why the Plan was not followed:

(NOTE: If a plan to respond to behavior has been developed, the Human Rights Committee must have a copy of the plan).

*(M5) Reason For Permanent Removal Of The Restraint:

*(M6) Describe Individual’s Condition During Restraint and Safety Checks:

TIME	INDIVIDUAL’S CONDITION	STAFF’S NAME	TIME	INDIVIDUAL’S CONDITION	STAFF’S NAME

(M7) Relief Periods :

START TIME	STOP TIME	INDIVIDUAL’S CONDITION	STAFF’S NAME

Individual: First Name:

Last Name:

SECTION III – ALL RESTRAINTS

INTERVIEW OF THE INDIVIDUAL:

*Person Interviewing the Individual:

*Did the Individual Wish to Comment? YES NO

If Yes, Comment:

If No, or Individual Incapable of Comment, Staff’s Interpretation of Individual’s Response to Restraint:

SECTION IV – ALL RESTRAINTS – Finalizing Initial Report

*Signature of Person Completing Initial Form:

*Date:

SECTION V – ALL RESTRAINTS – REVIEWS

***Restraint Manager (HOP) Review and Comment**

(A) To the best of your knowledge, were all procedures and protocols followed for this Restraint Action? YES NO

(B) If NO, areas where this Restraint Action needs improvement (select one or more)

Authorization of restraint

Renewal Order

Monitoring of restraint

Restraint training of staff

Physical examination of person restrained

Other, please describe in Comment Section

(C) Comments or Explanation:

* (D) Date Of Review:

* (E) Signature:

Individual: First Name:

Last Name:

SECTION V – ALL RESTRAINTS – REVIEWS – continued

Service Coordinator/Area Office – QMRP/Facility Review and Comment

*(A) Complete? YES NO

- *(B) If No, give reason: Inadequate Action Steps
 Incorrect Categorization
 Additional Information Needed
 Other: (please explain):

(C) Once Status is “Complete”, please review below:

(D) Date Received By DDS :

*(E) Date of Area/Facility Review:

*(F) Signature of Area/Facility Reviewer:

Human Rights Committee Review and Comments:

*Date of HRC Review:

*Signature of HRC:

Commissioner’s Review and Comments:

*Date of Commissioner’s Review:

*Signature of Human Rights Specialist
Performing Commissioner’s Review:

SECTION VI – CLOSING THE RECORD

*Date Closed:

*Closed By: