**COMMONWEALTH OF MASSACHUSETTS----DEPARTMENT OF MENTAL HEALTH**

***EMERGENCY RESTRAINT OR SECLUSION (R/S) FORM – PART A –* Revised 10/2022**

***NEW ORDER******RENEWAL ORDER*** **PATIENT DEBRIEFING & COMMENT FORM**

**Use new forms for each renewal MUST BE ATTACHED**

***NAME***  *DOB Med. Rec.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender:* *M F*

*Facility Unit Primary Language Race*

*Date this Admission Date R/S Started Time R/S Started Time R/S Ended Total R/S Time (at end of R/S)*

**WHAT TRIGGERED THE INCIDENT?**

**DESCRIBE ALTERNATIVES TRIED FROM INDIVIDUAL CRISIS PREVENTION PLAN (SAFETY TOOL) BEFORE RESTRAINT/SECLUSION USED:**

**CHECK/DESCRIBE OTHER INTERVENTIONS ATTEMPTED:**

\_\_\_\_\_\_\_\_ Ask HALTT (are you Hungry? Angry? Lonely? Thirsty? Tired?)

\_\_\_\_\_\_\_\_ Sensory Interventions \_\_\_\_\_\_\_\_ Offer quiet space

Activity change Offer a PRN medication

Separate from situation One-on-one intervention

\_\_\_\_\_\_\_\_ Other:

**TRAUMA CONSIDERATIONS:** history, R/S preferences including position & staff gender

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**RISK FACTORS: SIGNIFICANT MEDICAL PROBLEMS, PHYSICAL DISABILITIES:**

**Legally Authorized Representative (LAR)/Family Notified, at Time of R/S**

**Yes**  **Time**   **By**

**No \_\_\_\_\_\_\_\_\_\_ Reason why not \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/LAR requests no notification \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OR**

**Check if details of LAR/Family notification will be documented in Progress Note \_\_\_\_\_\_\_\_**

\*See: 104 CMR 27.12(8)(a)

**DESCRIBE BEHAVIOR REQUIRING EMERGENCY USE/CONTINUANCE OF R/S:**

**EMERGENCY INTERVENTION(S) USED:** Number interventions in the order used. This form covers all interventions used in response to the emergency situation covered by this order. Also place check mark beside intervention used for the most amount of time during an episode.

\_\_\_\_\_\_\_ Physical restraint

Seclusion

Mechanical restraint - Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ Medication restraint (fill in information below)

**TIME MEDICATION DOSAGE ROUTE**

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NURSE signature for medication restraint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***STAFF MONITOR TITLE TIME: FROM/TO***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURES/PRINT DATE/TIME SEEN**

**Authorized Staff Person\* Initiating R/S:**

**/**

**date time**

**Examining Authorized Clinician:**

**/**

**date time**

**Authorized Staff PersonAuthorizing Release:**

**/**

**date time**