

Report of Restraint or Seclusion

Date of Report: _____

Name of Member (Last, First, MI):	Provider Name:	Promise Number/Type:
MA Identifier Number:	Level of Care:	
Member Home Address, including County:	Provider Address:	
Member Telephone:	Provider Contact Name and Telephone Number:	
Date of Birth:	Date of Incident:	Time of Incident:
Location of Incident and Name of Provider Staff Involved:	Is this an addendum to a previously submitted report? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of initial report: _____	
<input type="checkbox"/> Seclusion Did the Member require treatment greater than first aid for injury as a result of the seclusion? <input type="checkbox"/> Yes* <input type="checkbox"/> No Duration of Seclusion: _____ Was the Member assessed by a Nurse during the seclusion? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the Member assessed by a Physician within 1 hour after the seclusion? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Restraint by Provider Staff: Type of restraint: <input type="checkbox"/> Chemical <input type="checkbox"/> Mechanical <input type="checkbox"/> Manual Duration of restraint: _____ If manual restraint, choose type of restraint: <input type="checkbox"/> standing <input type="checkbox"/> seated <input type="checkbox"/> supine <input type="checkbox"/> *prone Did the Member require treatment greater than first aid for injury that occurred as part of a restraint? <input type="checkbox"/> Yes* <input type="checkbox"/> No Was the Member assessed by a nurse after the restraint? <input type="checkbox"/> Yes <input type="checkbox"/> No Mechanical Restraint Only Was the Member assessed by a Physician within 1 hour after the restraint? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Instructions:

- This form must be completed for all restraints or seclusions in which **staff participate**, for any service that is funded by PerformCare and should be submitted within 24-hours of the occurrence of the restraint or seclusion.
- **If staff are not involved in the actual restraint or seclusion, this form does not need to be completed** (i.e. if staff are witnessing a restraint, but not participating, this form does not need to be completed by your agency).
- No other documentation is required to be submitted with this form unless additional information is requested by PerformCare.
- * If **an injury** occurred during restraint or seclusion or if a prone restraint occurred, the Critical Incident Report form must be completed instead of this form.

A "Report of Restraint or Seclusion Form" must be completed for EACH restraint or seclusion that occurs.

If a restraint leads to a seclusion, a separate form must be submitted for each event.

If there was a progression in Type of Restraint utilized, choose the most restrictive level of restraint.

If there was a progression in Type of Manual Restraint utilized, choose the most restrictive type of restraint.