

**PM FORM 7.3.1 Seclusion and Restraint Reporting DRAFT
Level I Programs**

PROGRAM/FACILITY LICENSE #: REPORT DATE:

Program/Facility Name:

AHCCCS Provider ID:

Address:

Contact Person/Title: Phone:

Name and Title of Person Authorizing the event:

Name and Title of Person Re-authorizing the event:

Reporting Information: Recipient Name: Age:

SS#: Gender: Male Female

CIS Identifier:

Medications: Diagnoses:

Recipient Behavioral Health Category: SMI Non-SMI SED Non-SED TXIX/XXI Eligible: Y N

Date/Time of Evaluation/Assessment:

Seclusion:

Date Administered: Time:

Name/Title: Duration of Seclusion: minutes/hours

Mechanical Restraint:

Date Administered: Time:

Name/Title: Duration of Restraint: minutes /hours

*If person is secluded and restrained, complete **both** the seclusion and mechanical restraint sections.

Personal Restraint:

Date Administered: Time:

Name/Title: Duration of Restraint: minutes /hours

*If person is secluded and restrained, complete **both** the seclusion and personal restraint sections.

Drug or Medication used as Restraint:

Date Administered: Time:

Name/Title:

List drugs/medications used as a restraint, method and dosage (other than PRN's):

*If person is secluded and restrained, complete **both** the seclusion and drug/medication restraint sections.

De-escalation methods and all less restrictive measures attempted prior to seclusion/restraint:

Reason for Restraint/Seclusion (include relevant information to describe facts/behaviors prior to the emergency safety situation and specific facts/behaviors justifying the use of seclusion or restraint):

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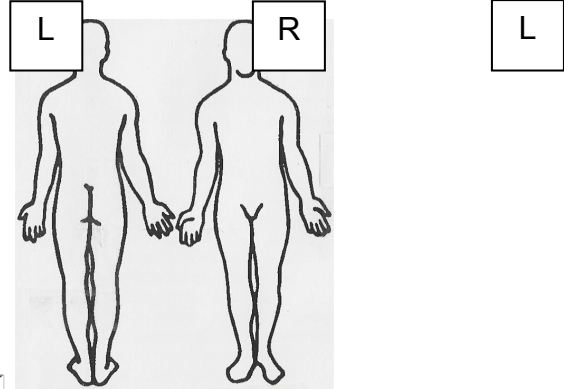
Was the person physically injured **DURING (not prior to)** the restraint or seclusion? Yes No

If yes, indicate:

1. Nature of the injury:

2. The level of medical intervention needed:

- None
- First Aid
- Medical (physician's order)
- Hospitalization
- Death



3. Indicate the location of the injury on the diagrams.

Date of Incident/Accident Report, if completed:

List names and titles of all staff involved in the seclusion and/or restraint procedure:

Date, Time and Person who monitored recipient's status while in Seclusion or Restraint.

	Date	Time (am / pm)	Person monitoring
Start			
End			

Attach internal documentation of face-to-face monitoring for all episodes that require such documentation per R9-20-602 or R9-21-204. Addendum content must include requirements contained in [Attachment 7.3.1, Seclusion and Restraint Monitoring Requirements](#).

Debriefing:

Date: Time:

Participants involved in seclusion and restraint debriefing:

Outcome of the debriefing, including action(s) taken to avoid future use of seclusion or restraint/identification of alternatives to seclusion and restraint (individual and systemic):

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Changes made to the Individual Service Plan (ISP) to reflect the debriefing:

Completed forms should be sent to the T/RBHA with which the facility is subcontracted within five days of the occurrence. A form must be completed for each individual secluded/restrained.