



**AHCCCS MEDICAL POLICY MANUAL**  
**POLICY 962, ATTACHMENT A - SECLUSION AND RESTRAINT INDIVIDUAL**  
**REPORTING FORM**

PROVIDER INFORMATION	
Report Date:	Program/Facility License #: Click here to enter text.
AHCCCS Provider ID: Click here to enter text.	Program/Facility Name: Click here to enter text.
Contact Person Phone #: Click here to enter text.	Provider Address: Click here to enter text.
Contact Person & Title: Click here to enter text.	
Name/Credentials/Title of Person Authorizing the Event: Click here to enter text.	
Name/Credentials/Title of Person Re-Authorizing the Event: Click here to enter text.	

MEMBER INFORMATION		
Member Name ( <i>Last, First, M.I.</i> ): Click here to enter text.		
Date of Birth:	Age:	Gender:
CIS ID: Click here to enter text.	AHCCCS ID: Click here to enter text.	
TXIX/XXI Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No	Member Behavioral Health Category: Click here to enter text.	
DDD: Click here to enter text.	CMDP: Click here to enter text.	
CRS:	ALTCS E/PD: Click here to enter text.	
Name of member's legal guardian (if applicable): Click here to enter text.		
Phone number of member's legal guardian (if applicable): Click here to enter text.		

CURRENT DIAGNOSES	
CODE	NAME

CURRENT MEDICATIONS			
MEDICATION	DOSAGE	FREQUENCY	METHOD OF ADMINISTRATION

**EVENT INFORMATION**

If a Seclusion and/or Restraint occur, complete all that apply. If the member is secluded and/or restrained, complete **BOTH** the seclusion and restraint sections.

**EVENT INFORMATION**

Type of Event: <input type="checkbox"/> Seclusion <input type="checkbox"/> Restraint		
Date:	Time (24-hour clock):	Evaluation/Initial face to face Assessment:
Did Member have medical condition(s) that placed them at greater risk for poor outcomes?	<input type="checkbox"/> Yes, describe:	
	<input type="checkbox"/> No	
Was the reason for restraint/seclusion and the conditions for release explained to the member?	<input type="checkbox"/> Yes, describe:	
	<input type="checkbox"/> No	

**DE-ESCALATION METHODS AND ALL LESS RESTRICTIVE MEASURES ATTEMPTED**

Select de-escalation methods and all less restrictive measures attempted prior to seclusion and/or restraint:	<input type="checkbox"/> Removing member from stimuli <input type="checkbox"/> Encouraging member to express feelings in appropriate manner <input type="checkbox"/> Conflict resolution <input type="checkbox"/> Re-directing the member <input type="checkbox"/> Offering prn medication, when necessary <input type="checkbox"/> Allowing member to pace and vent <input type="checkbox"/> Other (i.e. humor, distraction, 1:1, snack, etc.)
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**PERSONAL RESTRAINT (CHECK BOX)**

Date of Administration: <a href="#">Click here to enter text.</a>
Type of Restraint (i.e. Physical Hold): <a href="#">Click here to enter text.</a>
Time (24-hour clock): <a href="#">Click here to enter text.</a> Start time: <a href="#">Click here to enter text.</a> End time: <a href="#">Click here to enter text.</a>
Duration of Restraint: <a href="#">Click here to enter text.</a> Hours <a href="#">Click here to enter text.</a> minutes
Name/Credentials/Title of Primary Person involved in the Restraint: <a href="#">Click here to enter text.</a>

**MECHANICAL RESTRAINT (CHECK BOX)**

Date of Administration: <a href="#">Click here to enter text.</a>
Type of Restraint: <a href="#">Click here to enter text.</a>
Time (24-hour clock): <a href="#">Click here to enter text.</a> Start time: <a href="#">Click here to enter text.</a> End time: <a href="#">Click here to enter text.</a>
Duration of Restraint: <a href="#">Click here to enter text.</a> Hours <a href="#">Click here to enter text.</a> minutes
Name/Credentials/Title of Primary Person involved in the Restraint: <a href="#">Click here to enter text.</a>

**MEDICATION USED AS RESTRAINT**

DATE OF ADMINISTRATION	TIME OF ADMINISTRATION	MEDICATION	DOSAGE	FREQUENCY	METHOD OF ADMINISTRATION

**SECLUSION**

SECLUSION
Date of Administration: <a href="#">Click here to enter text.</a>
Time (24-hour clock): <a href="#">Click here to enter text.</a> Start time: <a href="#">Click here to enter text.</a> End time: <a href="#">Click here to enter text.</a>
Duration of Restraint: <a href="#">Click here to enter text.</a> hours/ <a href="#">Click here to enter text.</a> minutes
Name/Credentials/Title of Primary Person involved in the Restraint: <a href="#">Click here to enter text.</a>

**REASON FOR RESTRAINT AND/OR SECLUSION**

REASON FOR RESTRAINT/SECLUSION	
Include relevant information to describe facts/behaviors justifying the use of seclusion or restraint. Be descriptive (i.e., 'hitting and kicking staff' instead of 'physically aggressive toward staff').	
<input type="checkbox"/> Danger to Self (DTS)	Member Behaviors: <a href="#">Click here to enter text.</a>
	Member Quotes: <a href="#">Click here to enter text.</a>
<input type="checkbox"/> Danger to Others (DTO)	Member Behaviors: <a href="#">Click here to enter text.</a>
	Member Quotes: <a href="#">Click here to enter text.</a>

**MONITORING**

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The member must be personally examined at a minimum of every 15 minutes to ensure the behavioral health member's comfort and safety and determining the client's need for food, fluid, bathing and access to the toilet. The member must be checked every five minutes if the member has a medical condition that places him/her at a greater risk, as determined by the facility, by the restraint and/or seclusion. Attach internal documentation of face-to-face monitoring for all episodes that require such documentation per A.A.C.R9-21-204, A.A.C.R9-10-225 or A.A.C.R9-10-226. Addendum content must include requirements contained in AHCCCS Policy Exhibit 960-3, Seclusion and Restraint Requirements.

	Date	Time (24-hour clock)	Name of Primary Person involved in the Restraint	Credentials/Title of Primary Person involved in the Restraint
<b>Start</b>	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
<b>End</b>	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

**FACE-TO-FACE ASSESSMENT**

The member must receive a face-to-face assessment of physical and psychological well-being from the Psychiatrist, Registered Nurse (with one year of behavioral health experience) within one (1) hour of initiation of the restraint or seclusion.

Name/Credentials/Title of Primary Person involved in the Restraint: Click here to enter text.

Date of Assessment: Click here to enter text.

Time (24-hour clock) of Assessment: Click here to enter text.

Description of Member Condition: orientation, mood, affect behavior per R9-21-204 (physical and psychological wellbeing.)

**CLINICAL JUSTIFICATION TO CONTINUE RESTRAINT OR SECLUSION**

- Continues at risk for danger to self
- Continues at risk for danger to others
- No improvement of mental status
- Unable to follow verbal commands
- Medication administration not completed
  - Click here to enter text.

**CLINICAL JUSTIFICATION TO DISCONTINUE RESTRAINT OR SECLUSION**

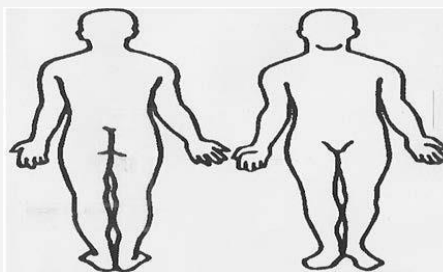
- No risk for danger to self
- No risk for danger to others
- Improvement of mental status
- Medication administration completed
- Able to follow verbal commands
- Meets all criteria for release

**INJURIES**

**INJURIES**

Was the member physically injured DURING (not prior to) the restraint and/or seclusion?    Yes    No

If yes, explain the nature of the injury and complete an Incident, Accident, and Death report:



Explain the level of medical intervention needed: [Click here to enter text.](#)

(e.g. first aid, physician, hospitalization, death)

**THIS SECTION MUST BE COMPLETED IF A MEMBER WAS INJURED DURING A SECLUSION/RESTRAINT PROCEDURE.**

**INCIDENT, ACCIDENT, AND DEATH (IF APPLICABLE)**

(The Contractor, TRBHA, or Tribal ALTCS, must ensure timely and accurate reporting of incidents, accidents, and deaths involving members to AHCCCS Clinical Quality Management.

Date of Incident, Accident, and Death Report completed:

Name/Credentials/Title of All Persons involved in the Seclusion/Restraint procedure:

**DEBRIEFING**

**MEMBER DEBRIEFING**

Date of Debriefing: [Click here to enter a date.](#)

Time (24-hour clock) of Debriefing: [Click here to enter text.](#)

Name/Credentials/Title of Primary Person involved in the Debriefing: [Click here to enter text.](#)

Other participants involved in the debriefing: [Click here to enter text.](#)

Information discussed during the debriefing: [Click here to enter text.](#)

**STAFF DEBRIEFING**

Date of Debriefing: [Click here to enter a date.](#)

Time (24-hour clock) of Debriefing: [Click here to enter text.](#)

Name/Credentials/Title of *all* staff in attendance in the Debriefing: [Click here to enter text.](#)

Identified intervention opportunities that may have prevented the incident: [Click here to enter text.](#)

Things that were done well and/or team strengths: [Click here to enter text.](#)

Ways the team could strengthen their response to future incidents: [Click here to enter text.](#)

Information discussed during the debriefing: [Click here to enter text.](#)

Procedures that can be implemented to prevent recurrence: [Click here to enter text.](#)

Systemic changes: [Click here to enter text.](#)

Alternatives for this member: [Click here to enter text.](#)

Outcome of Debriefing (including actions taken to avoid future use of seclusion or restraint/ identification or alternatives to seclusion and restraint on an individual and systemic levels): [Click here to enter text.](#)

**FOLLOW-UP**

FOLLOW-UP		
Was the treating provider notified?	<input type="checkbox"/> Yes, Name of provider: <input type="checkbox"/> No (If no, explain):	Date of Notification: Click here to enter text.
Was the family/guardian notified?	<input type="checkbox"/> Yes, Name and relationship of the person notified: <input type="checkbox"/> No (If no, explain):	Date of Notification: Click here to enter text.
Were the findings of face to face and nursing assessment discussed?	<input type="checkbox"/> Yes, with whom: <input type="checkbox"/> No (If no, explain):	Date of Discussion: Click here to enter text.
Was the need for other interventions/treatment reviewed?	<input type="checkbox"/> Yes, with whom: <input type="checkbox"/> No (If no, explain):	Date of Review: Click here to enter text.
Were revisions made to the treatment plan or scheduled?	<input type="checkbox"/> Yes, Describe revisions: <input type="checkbox"/> No (If no, explain):	Date of Revisions:
Were Seclusion and Restraint orders completed? Check all boxes that apply and attach orders when submitting Seclusion & Restraint form.		<input type="checkbox"/> Initial Order
		<input type="checkbox"/> Continuation Order
		<input type="checkbox"/> Discontinuation Order
Were monitoring sheets completed (every 15 minutes or every 5 minutes)? Attach monitoring sheets when submitting Seclusion & Restraint form.		<input type="checkbox"/> Yes, Date(s) of Completion:
		<input type="checkbox"/> No (If no, explain):
Were the findings of the assessment discussed?		<input type="checkbox"/> Yes, Date(s) of Completion:
		<input type="checkbox"/> No (If no, explain):

**FINAL SIGN-OFF**

Name of Director of Nursing or Designee reviewing Seclusion and Restraint Documentation: Click here to enter text.
Director of Nursing or Designee Phone Number: Click here to enter text.
Date of Sign-off: Click here to enter text.
Time (24-hour clock) of Sign-off: Click here to enter text.