Seclusion and Restraint Form

(Please write legibly)

FACILITY: _____

CONTACT NAME: _____

PHONE: _____

EMAIL: _____

PATIENT/CONSUMER NUMBER: _____
PATIENT/CONSUMER AGE: _____

Rationale for seclusion and/or restraint:
☐ Harmful to self ☐ Harmful to others

Methods used to avoid restraint and/seclusion:

☐ Ventilation of feelings ☐ Verbal reassurance/redirection ☐ 1:1 interaction with staff ☐ Reduction in stimuli

☐ Environmental change ☐ Limit setting ☐ Time away from others

Is the patient medically compromised? ☐ Yes ☐ No If yes, check all that apply:

☐ Morbid obesity ☐ Spinal injury ☐ Known history of cardiac or respiratory disease

☐ Recent vomiting ☐ Pregnancy ☐ On seizure precautions ☐ Other:_____

RN assessment: _____

_____

Physician's clinical assessment justifying use of seclusion or restraint: _____

_____

_____

Physician's behavioral criteria necessary for release: _____

_____

_____

Adults: ☐ Seclude for up to 4 hours ☐ Restrain for up to 4 hours
Children 9 – 17 Years of Age: ☐ Seclude for up to 2 hours ☐ Restrain for up to 2 hours
Children < 9 Years of Age: ☐ Seclude for up to 1 hour ☐ Restrain for up to 1 hour

Patient placed in:

☐ **SECLUSION:** Date: _____ Start Time: _____(AM/PM) End Time: _____(AM/PM)

☐ **PHYSICAL RESTRAINT:** Date: _____ Start Time: _____(AM/PM) End Time: _____(AM/PM)

☐ **CHEMICAL RESTRAINT:** Date: _____ Time: _____(AM/PM)

Medication Administered: _____ Dose: _____ ☐P.O. ☐I.M.

Medication Administered: _____ Dose: _____ ☐P.O. ☐I.M.

☐ **MECHANICAL RESTRAINT:** Date: _____ Start Time: _____(AM/PM) End Time: _____(AM/PM)

☐ cuff/belt ☐ legs ☐ wrist ☐ 4-point ☐ 5-point ☐ mitts ☐ restraint chair ☐ spit hood

Patient's family or legal guardian notified of the seclusion or restraint event?: ☐ Yes ☐ No

Physician Name: _____ Date: _____

Registered Nurse Name: _____ Date: _____

Scan and submit all reports to the Division of Public and Behavioral Health by email at DORsubmission@health.nv.gov