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 (Provide detailed narrative of incident and plan to prevent further denial of rights):
_____
_____
_____
_____

Physician's behavioral criteria necessary for release: _____
_____
_____

Patient Outcomes (Did patient improve following restraint? Did injury occur?): _____
_____
_____

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.

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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: _____

Physician Signature: _____ Date: _____

Registered Nurse Name: _____ Date: _____

Instructions for Submittal of Report

Scan and submit all reports to the Division of Public and Behavioral Health via secured, encrypted email to:

DORsubmission@health.nv.gov

If you are not able to submit the reports in a secured and encrypted email, you may mail the report to:

Division of Public and Behavioral Health
Attention: Executive Assistant
4150 Technology Way, Suite 300
Carson City, NV 89706