DCFS ASSIGNED FORM # ____

Commission on Behavioral Health
Seclusion and/or Restraint Emergency Procedures for Children and Youth
Denial of Rights v.1.11.2024

Print on gold paper. No names or HIPAA-identifiers. Date of Admission: ________ Medical Record #: ________ *(Required)*	Gender ☐ Male ☐ Female ☐ Transgender (Trans Man) ☐ Transgender (Trans Women) ☐ Gender Non-Conforming ☐ Other Height: ________ Weight: ________ Age: ________	Legal Status: ☐ Parental Custody ☐ Child Welfare Custody ☐ State ☐ County: ________ ☐ Youth Parole Custody ☐ Co-Custody
Race: *Check all that apply*		
☐ American Indian/Alaskan Native ☐ Asian ☐ Black American	☐ Native Hawaiian/Pacific Islander ☐ North African ☐ Middle Eastern	☐ White (Caucasian) ☐ Other ________
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown		
Programs/Facilities:		
☐ DCFS/Adolescent Treatment Center ☐ DCFS/Desert Willow ☐ DCFS/No. NV Children Services Enterprise ☐ Aurora Center for Healing ☐ Bamboo Sunrise ☐ Desert Parkway	☐ Desert Winds ☐ KW Legacy Ranch ☐ Reno Behavioral Hospital ☐ SAI Residential Treatment Center ☐ Seven Hills ☐ Sierra Sage	☐ Southern Hills ☐ UHS of Spring Mountain ☐ UHS Sahara ☐ Other ________ ☐ Other ________ ☐

Day of the week and shift:

(*Required*) IS THIS CHILD/YOUTH CURRENTLY ENROLLED IN SPECIALIZED FOSTER CARE? ☐ Yes ☐ No
(For reporting purposes only)

Discussed with physician: ☐ Yes ☐ No RN Initials: ________ Date/Time: ________
Physician verbal/phone orders by Dr. ________ Date/Time: ________
Physician Initials: ________ Date/Time: ________
Order noted by: ________ Date/Time: ________
Did RN extend order once up to the maximum allowable hours? ☐ Yes ☐ No
CONTINUATION ORDER: *The RN evaluation and documentation for continuation orders must include a face-to face-reassessment of the child/youth current behavior that warrants the extension of the restraint/seclusion.*

SECLUSION: ☐ Locked ☐ Unlocked ☐ N/A
Placed in Seclusion: DATE: ________ TIME: ________ ☐ AM ☐ PM
Released from Seclusion: DATE: ________ TIME: ________ ☐ AM ☐ PM Total time in minutes: ________

MECHANICAL RESTRAINT: ☐ Cuff/Belt ☐ Legs ☐ Wrists ☐ 4-point ☐ 5-point ☐ Mitts ☐ Geri Chair ☐ N/A
☐ Other ________
Placed in Restraint: DATE: ________ TIME: ________ ☐ AM ☐ PM
Released from Restraint: DATE: ________ TIME: ________ ☐ AM ☐ PM Total time in minutes: ________

PHYSICAL RESTRAINT: CPAR- ☐ Escort ☐ Standing Wrap/Basket Hold ☐ Seated ☐ Lying Supine (on back) ☐ N/A
☐ Lying Prone (on stomach) ☐ Other Hold Implemented, Type and Description: ________
Placed in Restraint: DATE: ________ TIME: ________ ☐ AM ☐ PM
Released from Restraint: DATE: ________ TIME: ________ ☐ AM ☐ PM
Total Time in Minutes: ________ Number of Staff Involved in Restraining Child/Youth: ________

CHEMICAL RESTRAINT: DATE: ________ TIME: ________ ☐ AM ☐ PM ☐ N/A
Medication Administered: ________ Dose: ________ ☐ PO ☐ IM
Medication Administered: ________ Dose: ________ ☐ PO ☐ IM
Medication Administered: ________ Dose: ________ ☐ PO ☐ IM
Results After one Hour (Explain) ________

Behavioral Descriptors of Events: (CHECK ALL THAT APPLY)		
☐ Attempted elopement ☐ Bites ☐ Cuts ☐ Hits ☐ Imminent harm to others	☐ Imminent harm to self ☐ Kicks ☐ Physical fighting ☐ Property destruction ☐ Punches	☐ Pushes ☐ Scratches ☐ Spits ☐ Threatening gestures ☐ Throwing objects at another

Descriptive Narrative of Behaviors:

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Is Child/Youth Medically Compromised: ☐ Yes ☐ No (CHECK ALL THAT APPLY)

☐ Known Hx of Cardiac or Respiratory Disease ☐ Morbid Obesity ☐ Seizure Precautions	☐ Pregnancy ☐ Recent Vomiting	☐ Spinal Injury ☐ Other

Injury to Child/Youth During Procedure: ☐ Yes ☐ No (If Yes, describe injury and any treatment)

Staff Intervention Prior to Restraint/Seclusion (CHECK ALL THAT APPLY)

☐ Ventilation of Feelings ☐ Verbal Reassurance ☐ Verbal Redirection ☐ Timeout	☐ Environmental Change ☐ Praise/Empathy Statement ☐ 1:1 Interaction w/Staff ☐ Coupling Statements	☐ Limit Setting ☐ Rationale/Reality Statements ☐ Reduction in Stimuli

Describe Interventions Prior to Procedure:

Does the Child/Youth have a Personal Safety Plan (Safety Assessment and Crisis Plan)? ☐ Yes ☐ No

Was the Plan followed? ☐ Yes ☐ No Was there a Debriefing? ☐ Yes ☐ No

Plan to prevent further events (Make Note of Any Changes to the Positive/Individual Behavior Plan, and attach Plan):

Names and Titles of Staff Involved: ______________________________ ______________________________
Name: Title:

Names and Titles of Witnesses: ______________________________ ______________________________
Name: Title:

Legally Responsible Individual/Parent/Guardian/Custodian Notified ☐ Yes ☐ No

Name of Staff Member Providing Notification: ______________________Date:__________ Time:_________ ☐ AM ☐ PM

Nursing Report: Findings and Treatment:

Signature/Title:______________________________Date:____________________

Physician's Report: Findings and Treatment:

Signature/Title:______________________________Date:____________________

Program Manager's (DCFS CPM I) Review: Findings and Treatment:

Signature/Title:______________________________Date:____________________

DCFS Clinical Program Manager II's Review: Findings and Treatment

Signature/Title:______________________________Date:____________________

DCFS/Private Facility ADMINISTRATIVE REVIEW: Comments- ______________________________ DCFS Dep. Admin. /Facility Admin. Date:	COMMISSION REVIEW: Comments- ______________________________ Commissioner Date:

NV Commissioner of Behavioral Health Comments: