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.
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: ______________

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