

# Seclusion and Restraint Form

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](mailto:DORsubmission@health.nv.gov)**

Revised 5/18/2023