

**PM FORM 7.3.1 Seclusion and Restraint Reporting
Level I Programs**

PROGRAM/FACILITY LICENSE #: _____ REPORT DATE: _____

Program/Facility Name: _____

AHCCCS Provider ID: _____

Address: _____

Contact Person/Title: _____ Phone: _____

Name and Title of Person Authorizing the event: _____

Name and Title of Person Re-authorizing the event: _____

Reporting Information:

CIS Identifier: _____ Gender M F

Medications: _____ Diagnoses: _____

Recipient Name: _____ Age: _____ SS#: _____

Recipient Behavioral Health Category: _____ (SMI, NSMI, SED, NSED) TXIX/XXI Eligible Y N

Date/Time of Evaluation/Assessment: _____

Seclusion:

Date Administered: _____ / _____ / _____ Time: _____ am / pm

Name/Title: _____ Duration of Seclusion: _____ minutes/hours

Mechanical Restraint:

Date Administered: _____ / _____ / _____ Time: _____ am / pm

Name/Title: _____ Duration of Restraint: _____ minutes /hours

*If person is secluded and restrained, complete **both** the seclusion and mechanical restraint sections.

Personal Restraint:

Date Administered: _____ / _____ / _____ Time: _____ am / pm

Name/Title: _____ Duration of Restraint: _____ minutes /hours

*If person is secluded and restrained, complete **both** the seclusion and personal restraint sections.

Drug or Medication used as Restraint:

Date Administered: _____ / _____ / _____ Time: _____ am / pm

Name/Title: _____

List drugs/medications used as a restraint, method and dosage (other than PRN's): _____

*If person is secluded and restrained, complete **both** the seclusion and drug/medication restraint sections.

De-escalation methods and all less restrictive measures attempted: _____

Reason for Restraint/Seclusion (include relevant information to describe facts/behaviors prior to the emergency safety situation and specific facts/behaviors justifying the use of seclusion or restraint):

**PM FORM 7.3.1 Seclusion and Restraint Reporting
Level I Programs**

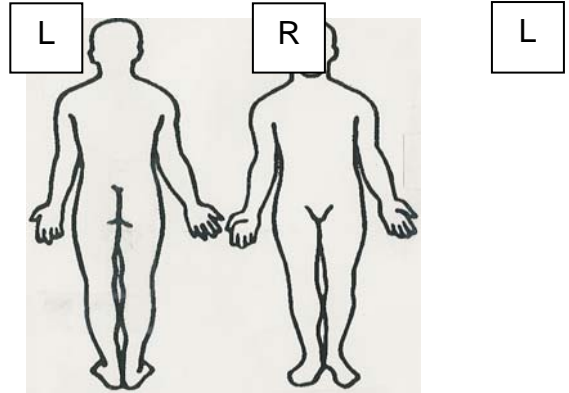
Was the person physically injured **DURING (not prior to)** the restraint or seclusion? _____ Yes No

If yes, indicate:

1. Nature of the injury: _____

2. The level of medical intervention needed:

- None
- First Aid
- Medical (physician's order)
- Hospitalization
- Death



3. Indicate the location of the injury on the diagrams.

Incident/Accident Report Completed? Date: _____

List names and titles of all staff involved in the seclusion and/or restraint procedure:

Date, Time and Person who monitored recipient's status while in Seclusion or Restraint.

	Date	Time (am / pm)	Person monitoring
Start			
End			

Attach internal documentation of face-to-face monitoring for all episodes that require such documentation per R9-20-602 or R9-21-204. Addendum content must include requirements contained in [Attachment 7.3.1, Seclusion and Restraint Monitoring Requirements](#).

Debriefing:

Date: _____ Time: _____

Participants involved in seclusion and restraint debriefing:

Outcome of the debriefing, including action(s) taken to avoid future use of seclusion or restraint/identification of alternatives to seclusion and restraint (individual and systemic):

**PM FORM 7.3.1 Seclusion and Restraint Reporting
Level I Programs**

Changes made to the Individual Service Plan (ISP) to reflect the debriefing:

Completed forms should be sent to the T/RBHA with which the facility is subcontracted within five days of the occurrence. A form must be completed for each individual secluded/restrained.