PROVIDER INFORMATION	
Report Date:	Program/Facility License #:
AHCCCS Provider ID:	Program/Facility Name:
Contact Person Phone #:	Provider Address:
Contact Person and Title:	
Name/Credentials/Title of Person Authorizing the Event:	
Name/Credentials/Title of Person Re-Authorizing the Event:	

MEMBER INFORMATION		
Member Name (Last, First, M.I.):		
Date of Birth:	Age:	Gender:
AHCCCS ID:		
TXIX/XXI Eligible: ☐ Yes ☐ No	Member Behavioral Health Category (SMI, GMH/SA, Child):	
DDD:	CMDP:	
Court Ordered Treatment (COT): ☐ Yes ☐ No	ALTCS E/PD:	
Name of member's legal guardian/health care decision maker (if applicable):		
Phone number of member's legal guardian/health care decision maker (if applicable):		

CURRENT DIAGNOSES	
CODE	NAME

Effective Dates: 7/01/16, 07/12/17, 10/01/18, 10/01/19, 10/01/20
Approval Dates: 04/06/17, 06/13/18, 10/03/19, 05/07/20

CURRENT MEDICATIONS			
MEDICATION	DOSAGE	FREQUENCY	METHOD OF ADMINISTRATION

If a Seclusion and/or Restraint occur, complete all that apply. If the member is secluded and/or restrained, complete **BOTH** the seclusion and restraint sections.

EVENT INFORMATION	
Type of Event: ☐ Seclusion ☐ Personal Restraint ☐ Chemical Restraint ☐ Mechanical Restraint	
Did Member have medical condition(s) that placed them at greater risk for poor outcomes?	☐ Yes, describe:
	☐ No
Was the reason for seclusion/restraint and the conditions for release explained to the member?	☐ Yes, describe:
	☐ No

DE-ESCALATION METHODS AND ALL LESS RESTRICTIVE MEASURES ATTEMPTED	
Select de-escalation methods and all less restrictive measures attempted prior to seclusion and/or restraint:	☐ Removing member from stimuli
	☐ Encouraging member to express feelings in appropriate manner
	☐ Conflict resolution
	☐ Re-directing the member
	☐ Offering prn medication, when necessary
	☐ Allowing member to pace and vent
	☐ Other (e.g. humor, distraction, 1:1, snack)

PERSONAL RESTRAINT (CHECK BOX)		
Date of Administration:		
Type of Restraint (e.g. Physical Hold):		
Time (24-hour clock) Start time:	End time:	
Duration of Restraint:	Hours:	Minutes:
Name/Credentials/Title of Primary Individual involved in the Restraint:		

MECHANICAL RESTRAINT (CHECK BOX)		
Date of Administration:		
Type of Restraint:		
Time (24-hour clock) Start time:	End time:	
Duration of Restraint:	Hours:	Minutes:
Name/Credentials/Title of Primary Person involved in the Restraint:		

MEDICATION USED AS RESTRAINT					
DATE OF ADMINISTRATION	TIME OF ADMINISTRATION	MEDICATION	DOSAGE	FREQUENCY	METHOD OF ADMINISTRATION

SECLUSION		
Date of Administration:		
Time (24-hour clock):	Start time:	End time:
Duration of Restraint:	Hours:	Minutes:

Effective Dates: 7/01/16, 07/12/17, 10/01/18, 10/01/19, 10/01/20
Approval Dates: 04/06/17, 06/13/18, 10/03/19, 05/07/20

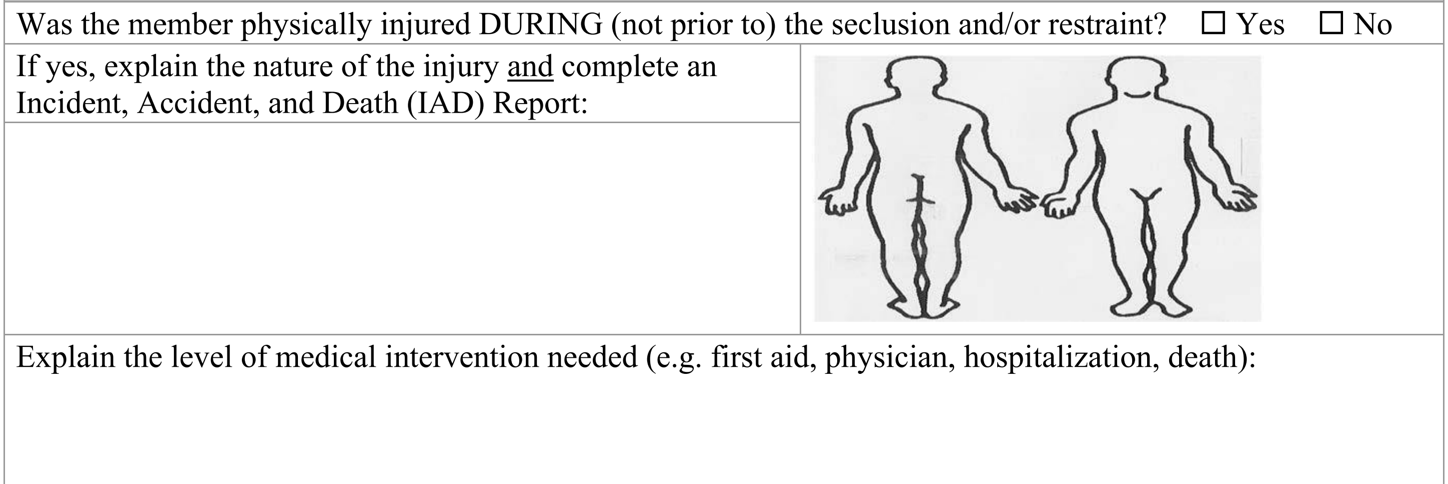
Name/Credentials/Title of Primary Person involved in the Restraint:

REASON FOR RESTRAINT/SECLUSION	
Include relevant information to describe facts/behaviors justifying the use of seclusion or restraint. Be descriptive (e.g. 'hitting and kicking staff' instead of 'physically aggressive toward staff').	
☐ Danger to Self (DTS)	Member Behaviors:
	Member Quotes:
☐ Danger to Others (DTO)	Member Behaviors:
	Member Quotes:

MONITORING				
The member must be personally examined at a minimum of every 15 minutes to ensure the member's comfort and safety and to determine the member's need for food, fluid, bathing, and access to the toilet. If the member has any medical condition that may be adversely affected by the restraint or seclusion, the member shall be monitored every five minutes, until the medical condition resolves, if applicable. Attach internal documentation of face-to-face monitoring for all episodes that require such documentation per A.A.C.R9-21-204, A.A.C.R9-10-225, or A.A.C.R9-10-226. Addendum content must include requirements contained in AMPM Policy 962, Seclusion and Restraint Requirements.				
	Date	Time (24-hour clock)	Name of Primary Individual involved in the Restraint	Credentials/Title of Primary Person involved in the Restraint
Start				
End				

FACE-TO-FACE ASSESSMENT
The member must receive a face-to-face assessment of physical and psychological well-being from the Psychiatrist or Registered Nurse (with one year of behavioral health experience) within one (1) hour of initiation of the restraint or seclusion.
Name/Credentials/Title of Primary Person involved in the Restraint:
Date of Assessment:
Time (24-hour clock) of Assessment:
Description of Member Condition (orientation, mood, affect, behavior per R9-21-204 (physical and psychological wellbeing)):

CLINICAL JUSTIFICATION TO DISCONTINUE SECLUSION OR RESTRAINT
☐ No risk for danger to self
☐ No risk for danger to others
☐ Improvement of mental status
☐ Medication administration completed
☐ Able to follow verbal commands
☐ Meets all criteria for release

INJURIES	
Was the member physically injured DURING (not prior to) the seclusion and/or restraint? ☐ Yes ☐ No	
If yes, explain the nature of the injury and complete an Incident, Accident, and Death (IAD) Report:	
Explain the level of medical intervention needed (e.g. first aid, physician, hospitalization, death):	

THIS SECTION MUST BE COMPLETED IF A MEMBER WAS INJURED DURING A SECLUSION AND/OR RESTRAINT PROCEDURE

INCIDENT, ACCIDENT, AND DEATH (IF APPLICABLE)
(The Contractor, TRBHA, or Tribal ALTCS, must ensure timely and accurate reporting of incidents, accidents, and deaths involving members to AHCCCS/ Quality Management.
Date of Incident, Accident, and Death Report completed:
Name/Credentials/Title of All Individuals involved in the Seclusion/Restraint procedure:
MEMBER DEBRIEFING
Date of debriefing:
Time (24-hour clock) of debriefing:
Name/Credentials/Title of primary individual involved in the Debriefing:
Other participants involved in the debriefing:

Information discussed during the debriefing:

STAFF DEBRIEFING
Date of debriefing:
Time (24-hour clock) of debriefing:
Name/Credentials/Title of all staff in attendance in the debriefing:
Identified intervention opportunities that may have prevented the incident:
Things that were done well and/or team strengths:
Ways the team could strengthen their response to future incidents:
Information discussed during the debriefing:
Procedures that can be implemented to prevent recurrence: Systemic changes: Alternatives for this member:
Outcome of debriefing (including actions taken to avoid future use of seclusion or restraint and identification or alternatives to seclusion and restraint on individual and systemic levels):

FOLLOW-UP		
Was the treating provider notified?	☐ Yes, Name of provider:	Date of Notification:
	☐ No (If no, explain):	
Was the family/guardian/health care decision maker notified?	☐ Yes, Name and relationship of the person notified:	Date of Notification:
	☐ No (If no, explain):	
Were the findings of face-to-face monitoring and nursing assessment discussed?	☐ Yes, with whom:	Date of Discussion:
	☐ No (If no, explain):	
Was the need for other interventions or treatments reviewed?	☐ Yes, with whom:	Date of Review:
	☐ No (If no, explain):	
Were revisions made to the treatment plan or scheduled?	☐ Yes, Describe revisions:	Date of Revisions:
	☐ No (If no, explain):	
Were Seclusion and Restraint orders completed? Check all boxes that apply and attach orders when submitting Seclusion and Restraint form.		☐ Initial Order
		☐ Continuation Order
		☐ Discontinuation Order
Were monitoring sheets completed (every 15 minutes or every 5 minutes)? Attach monitoring sheets when submitting Seclusion and Restraint form.		☐ Yes, Date(s) of Completion:
		☐ No (If no, explain):

FINAL SIGN-OFF
Name of Director of Nursing or Designee reviewing Seclusion and Restraint Documentation:
Director of Nursing or Designee Phone Number:
Date of Sign-off:
Time (24-hour clock) of Sign-off: