Emergency Physical Restraint Report

**Attach this form to the Incident Report for any physical interventions beyond blocking and not part of bx plan*
Restraints that are all part of one incident may be documented on one form. Type or handwrite legibly in blue or black ink. No white out.

Individual Name: Client First name last name	Region: Number 1-10	DOB: Month/ Day/ Year
Date of Incident: Month/ Day/ Year	Time of incident: Hour: Minute ☐am ☐pm Mark one	
Name of Agency providing services at the time of incident: Vendor/Provider Agency or N/A		

Describe the least restrictive method utilized prior to restraint:
Examples- verbal de-escalation, coping skills, physical prompts, clinical support, consulting therapist, etc.

Identify category for reason of emergency restraint:
☐ Substantial risk of serious physical harm/ injury to self or others (without intervention, injury would likely occur)
☐ Occurrence of serious physical harm/ injury to self or others (actual injury caused to self or others)
☐ Substantial risk of serious destructive behavior (without intervention this behavior could lead to harm of self or others)
☐ Occurrence of serious destructive behavior (actual destructive behavior occurred)

Describe the physical restraint intervention utilized:
Describe physical intervention technique utilized (not just name of technique)

Duration of restraint:
Actual number of minutes that restraint was applied (best estimation)

Is there a behavioral plan in place to respond to emergency situations?
YES ☐ NO ☐ (check yes or no if the individual has a behavior plan)

Is the intervention of physical restraint part of an approved behavior plan?
YES ☐ NO ☐ (check yes or no. If this intervention is part of behavior plan, this form might not be required)

Describe response of person being restrained <u>during</u> the use of restraint:
How did the individual act during restraint (e.g. screaming, struggling against restraint, crying, quiet/ passive, etc.)

Describe the response of the person being restrained <u>after</u> the use of restraint:
How did the individual act after restraint (e.g. crying, quiet/ passive, sleeping, returned to normal routine, angry, talked on phone, took shower, apologetic, etc.)

Was the person visually/ verbally checked for potential injury after the restraint?
YES ☐ NO ☐ (check yes or no if you checked them for injury. If no, explain why) Describe: Describe injury, if any. If no injury, write "no injury".

Identify the staff person(s) who conducted the restraint:
Print name(s) of staff person(s) who performed restraint.

Reporter Printed Name: First name last name of person completing report	Title Job title	
Signature of Reporter Signature of person completing report, as per agency policy	Date Month/ Day/ Year	Time Hour: Minute

REVIEWS

Program Manager Review of the physical intervention, including debriefing with staff (e.g. why was it appropriate, was retraining necessary, etc.)
Vendor Agency Manager review of physical restraint, which could include follow-up/ next steps, preventative measures, and processing with staff, individual or team (e.g. why was it appropriate, was retraining necessary, etc.).

What is the physical intervention/ restraint program that is utilized by the agency (i.e. MANDT, MOAB, etc.)?
Print name of restraint program(s) used by agency.

Were all the staff involved trained and currently certified in this physical intervention/ restraint technique?
YES ☐ NO ☐ (check yes or no)

Signature of Program Manager First name last name of Manager completing report	Date Month/ Day/ Year	Time Hour: Minute
Printed Name of Program Manager First name last name of Manager reviewing report	Title Job title	