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PROVIDER INFORMATION	
Report Date:	Program/Facility License #: *Click here to enter text.*
AHCCCS Provider ID: *Click here to enter text.*	Program/Facility Name: *Click here to enter text.*
Contact Person Phone #: *Click here to enter text.*	Provider Address: *Click here to enter text.*
Contact Person and& Title: *Click here to enter text.*	
Name/Credentials/Title of Person Authorizing the Event: *Click here to enter text.*	
Name/Credentials/Title of Person Re-Authorizing the Event: *Click here to enter text.*	

MEMBER INFORMATION		
Member Name (Last, First, M.I.):: *Click here to enter text.*		
Date of Birth:	Age:	Gender:
CIS ID: *Click here to enter text.*	AHCCCS ID: *Click here to enter text.*	
TXIX/XXI Eligible: ☐ Yes ☐ No	Member Behavioral Health Category: *Click here to enter text.*	
DDD: *Click here to enter text.*	CMDP: *Click here to enter text.*	
CRS:	ALTCS E/PD: *Click here to enter text.*	
Name of member's legal guardian/health care decision maker[1] (if applicable): *Click here to enter text.*		
Phone number of member's legal guardian/health care decision maker (if applicable):: *Click here to enter text.*		

CURRENT DIAGNOSES	
CODE	NAME

CURRENT MEDICATIONS			
MEDICATION	DOSAGE	FREQUENCY	METHOD OF ADMINISTRATION

[1] Added to align with policy standards

EVENT INFORMATION

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 ☐ Restraint		
Date:	Time (24-hour clock):	Evaluation/Initial face to face Assessment:
Did Member have medical condition(s) that placed them at greater risk for poor outcomes?		☐ Yes, describe:
		☐ No
Was the reason for ~~restraint/~~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.~~i.e.~~ humor, distraction, 1:1, snack~~, etc.~~)

PERSONAL RESTRAINT (CHECK BOX)
Date of Administration: *Click here to enter text.*
Type of Restraint (e.g.~~i.e.~~ Physical Hold):*Click here to enter text.*
Time (24-hour clock):*Click here to enter text.* Start time: *Click here to enter text.* End time: *Click here to enter text.*
Duration of Restraint: *Click here to enter text.* Hours *Click here to enter text.* minutes
Name/Credentials/Title of Primary ~~Person~~ Individual involved in the Restraint: *Click here to enter text.*

MECHANICAL RESTRAINT (CHECK BOX)
Date of Administration: *Click here to enter text.*
Type of Restraint~~:~~: *Click here to enter text.*
Time (24-hour clock):*Click here to enter text.* Start time: *Click here to enter text.* End time: *Click here to*

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enter text.
Duration of Restraint: *Click here to enter text.* Hours *Click here to enter text.* minutes
Name/Credentials/Title of Primary Person involved in the Restraint: *Click here to enter text.*

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

SECLUSION

SECLUSION
Date of Administration: *Click here to enter text.*
Time (24-hour clock): *Click here to enter text.* Start time: *Click here to enter text.* End time: *Click here to enter text.*
Duration of Restraint: *Click here to enter text.* hours/ *Click here to enter text.* minutes
Name/Credentials/Title of Primary Person involved in the Restraint: *Click here to enter text.*

REASON FOR RESTRAINT AND/OR SECLUSION

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

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MONITORING

MONITORING				
The member must be personally examined at a minimum of every 15 minutes to ensure the ~~behavioral health~~ member's comfort and safety and ~~determining~~ to determine the ~~client's~~ member's need for food, fluid, bathing, and access to the toilet~~.~~. ~~The member must be checked every five minutes i~~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~~places him/her at a greater risk~~, until the medical condition resolves, if applicable.~~, as determined by the facility, by the restraint and/or seclusion.~~ . 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 ~~AHCCCS~~ AMPM Policy ~~Exhibit 960-3~~962, Seclusion and Restraint Requirements.				
	Date	Time (24-hour clock)	Name of Primary ~~Person~~ Individual involved in the Restraint	Credentials/Title of Primary Person involved in the Restraint
Start	*Click here to enter text.*	*Click here to enter text.*	*Click here to enter text.*	*Click here to enter text.*
End	*Click here to enter text.*	*Click here to enter text.*	*Click here to enter text.*	*Click here to enter text.*

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: *Click here to enter text.*
Date of Assessment: ***Click here to enter text.***
Time (24-hour clock) of Assessment: *Click here to enter text.*
Description of Member Condition~~:~~ (orientation, mood, affect, behavior per R9-21-204 (physical and psychological wellbeing~~.~~)):
~~CLINICAL JUSTIFICATION TO CONTINUE RESTRAINT OR SECLUSION~~[2]
~~☐ Continues at risk for danger to self~~
~~☐ Continues at risk for danger to others~~
~~☐ No improvement of mental status~~
~~☐ Unable to follow verbal commands~~
~~☐ Medication administration not completed~~ *Click here to enter text.*

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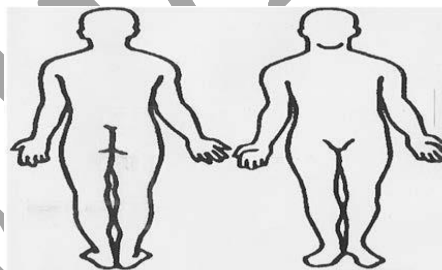
[2] Removed due to duplicate reporting requirement that is also documented on the monitoring form and/or written order.

CLINICAL JUSTIFICATION TO DISCONTINUE SECLUSION OR RESTRAINT ~~OR SECLUSION~~
☐ 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

INJURIES	
Was the member physically injured DURING (not prior to) the seclusion and/or restraint ~~and/or seclusion~~? ☐ Yes ☐ No	
If yes, explain the nature of the injury and complete an Incident, Accident, and Death (IAD) R~~r~~eport:	
Explain the level of medical intervention needed (e.g. first aid, physician, hospitalization, death): *Click here to enter text.* ~~(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-~~/Clinical~~ Quality Management.
Date of Incident, Accident, and Death Report completed:
Name/Credentials/Title of All ~~Persons~~ Individuals involved in the Seclusion/Restraint procedure:

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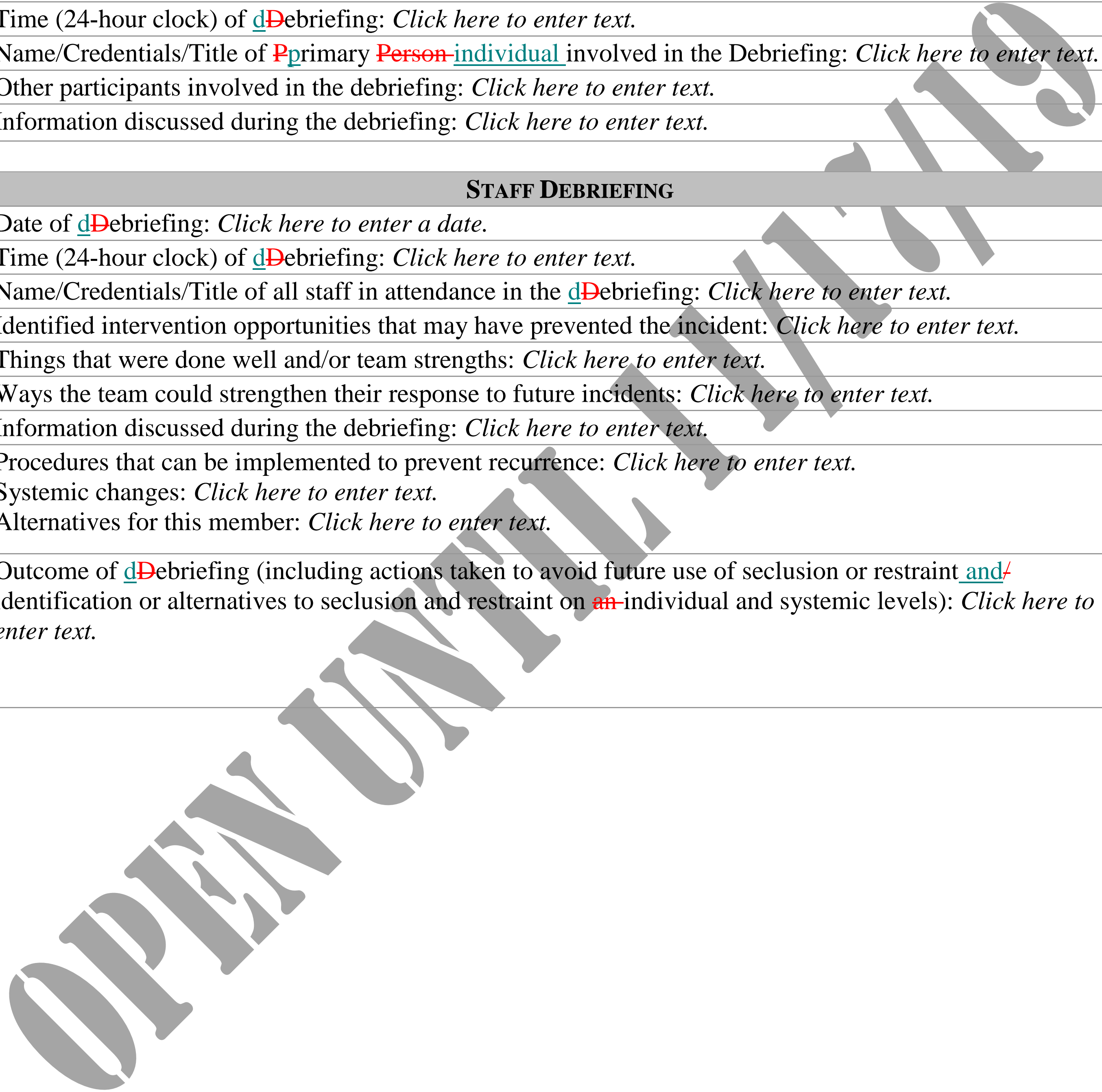
DEBRIEFING

MEMBER DEBRIEFING
Date of d~~D~~ebriefing: *Click here to enter a date.*
Time (24-hour clock) of d~~D~~ebriefing: *Click here to enter text.*
Name/Credentials/Title of ~~P~~primary ~~Person~~ individual involved in the Debriefing: *Click here to enter text.*
Other participants involved in the debriefing: *Click here to enter text.*
Information discussed during the debriefing: *Click here to enter text.*

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



FOLLOW-UP

FOLLOW-UP		
Was the treating provider notified?	☐ Yes, Name of provider: ☐ No (If no, explain):	Date of Notification: *Click here to enter text.*
Was the family/guardian/health care decision maker notified?	☐ Yes, Name and relationship of the person notified: ☐ No (If no, explain):	Date of Notification: *Click here to enter text.*
Were the findings of face-to--face monitoring and nursing assessment discussed?	☐ Yes, with whom: ☐ No (If no, explain):	Date of Discussion: *Click here to enter text.*
Was the need for other interventions or /treatments reviewed?	☐ Yes, with whom: ☐ No (If no, explain):	Date of Review: *Click here to enter text.*
Were revisions made to the treatment plan or scheduled?	☐☐ Yes, Describe revisions: ☐ No (If no, explain):	Date of Revisions:
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):	
~~Were the findings of the assessment discussed?~~[3]	~~☐ Yes, Date(s) of Completion:~~ ~~☐ No (If no, explain):~~	

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FINAL SIGN-OFF
Name of Director of Nursing or Designee reviewing Seclusion and Restraint Documentation: *Click here to enter text.*
Director of Nursing or Designee Phone Number: *Click here to enter text.*
Date of Sign-off: *Click here to enter text.*
Time (24-hour clock) of Sign-off: *Click here to enter text.*

[3] Removed- Duplicated above by combining monitoring review with assessment review.