DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-62607 (03/2017)

STATE OF WISCONSIN
Wisconsin Statutes
§§ 50.02(2) and 51.61(1)(i)
WI Administrative Code
DHS § 94.10

REQUEST FOR USE OF RESTRAINTS, ISOLATION, OR PROTECTIVE EQUIPMENT AS PART OF A BEHAVIOR SUPPORT PLAN

Although completion of this form is voluntary, all the information requested on this form needs to be submitted as part of the approval process. Personally identifiable information is collected on this form for the sole purpose of identifying the program participant and processing the request, and will not be used for any other purpose.

Name – **Consumer**	Date of Birth (mm/dd/yyyy)

Type of Request	Funding Program
☐ New ☐ Review	☐ Family Care ☐ County Waiver ☐ IRIS ☐ Medicaid ☐ Medicare ☐ Private Pay ☐ Other

Guardian

Name - Guardian			Telephone Number - Guardian
Address – Street	City	State	Zip Code

Current Residence—Consumer *(Check one and provide requested information)*

☐ **Personal/Family Residence**

Address – Street	City	State	Zip Code

☐ **Licensed or Certified Provider**

Name – **Provider**		Provider Type	☐ Certified ☐ Licensed
Address – Street		City	State / Zip Code
Telephone Number	Fax Number	Email Address	

☐ **Other**

Name and Description – **Other**

Address – Street	City	State	Zip Code
Telephone Number	Fax Number	Email Address	

Proposed Placement

☐ Yes ☐ No Is the consumer's proposed placement other than the current residence? *If "yes," complete the following.*

Name – **Provider**		Provider Type	
Address – Street		City	State / Zip Code
Telephone Number	Fax Number	Email Address	

Entity Submitting This Request

Name – **Entity** *(MCO, county agency, etc.)*			Date Submitted (mm/dd/yyyy)
Address – Agency		City	State / Zip Code
Agency Contact Person	Telephone Number	Fax Number	Email Address

Proposed Procedure/Device *(Check "yes" if the following apply and provide requested information.)*

☐ Yes **Physical Restraints**	Any device, garment, or physical hold that (a) restricts voluntary movement of a person's body or access to any part of the body **and** (b) cannot be easily removed by the individual.

Procedure/Device

Purpose

Plan *(Specify where procedure or device is used, when, length of time, etc.)*

Desired Outcome

☐ Yes **Isolation**	Physical or social separation from others by actions of staff but does not include separation in order to prevent the spread of communicable disease or cool down periods in an unlocked room as long as presence in the room by the resident is voluntary.

Procedure/Device

Purpose

Plan *(Specify where procedure or device is used, when, length of time, etc.)*

Desired Outcome

☐ Yes **Protective Equipment**	The application of a device to any part of a person's body that *prevents tissue damage or other physical harm* due to a person's behavior **and** cannot be easily removed by the individual.

Identify proposed procedure or device and why these strategies are needed. Attach relevant photos, manufacturer specifications, or literature.

Procedure/Device

Purpose

Plan *(Specify where procedure or device is used, when, length of time, etc.)*

Desired Outcome

Personal Summary

Type of Employment/Daytime Activity

Support Systems *(Names, contact information, and relationships)*

Interests

Dislikes

Health Considerations

Diagnoses

Health Concerns

Current Height and Weight

Medications

Medication	Dose	Purpose	Prescribing Physician

Health Providers

Name – **Primary Physician**		Telephone Number	
Address – Street	City	State	Zip Code
Name – **Psychiatrist**		Telephone Number	
Address – Street	City	State	Zip Code
Name – **Psychologist/Therapist**		Telephone Number	
Address – Street	City	State	Zip Code
Name – **Neurologist**		Telephone Number	
Address – Street	City	State	Zip Code
Name and Title/Profession – **Other**		Telephone Number	
Address – Street	City	State	Zip Code
Name and Title/Profession – **Other**		Telephone Number	
Address – Street	City	State	Zip Code
Name and Title/Profession – **Other**		Telephone Number	
Address – Street	City	State	Zip Code

Target Behavior

Describe or attach the individual's challenging behaviors and the situations in which they occur.

Describe or attach the frequency and intensity of the above behaviors.

Describe or attach the patterns that have been observed when the behavior occurs; i.e., what triggers the behavior.

Describe or attach the plan currently being done proactively to prevent these behaviors from occurring.

Previous Support Strategies or Interventions

List and explain or attach previous support strategies or interventions, when they were tried, how long they were tried, and the outcomes.

Previous Support Strategy or Intervention

Outcome

Previous Support Strategy or Intervention

Outcome

Previous Support Strategy or Intervention

Outcome

Previous Support Strategy or Intervention

Outcome

Current and Proposed Strategies

Describe or attach the current and proposed strategies and safeguards for target behaviors. Include staffing patterns, level of supervision, restrictions, or limitations. Attach the current support plan/behavioral support plan, OT and PT evaluations, physician orders, informed consent by the consumer or guardian.

Need

Explain or attach why the current strategies are ineffective. Describe what more is needed.

Risks and Benefit

Describe a risk and benefit analysis for the use of the restraint, isolation, or protective equipment.

Physician Orders

Include written authorization by a physician, identifying the type of restraint ordered, the indication for its use, the time period for its application, and any potential contraindications with use of proposed restrictive measures.

Intervention

Describe or attach the sequential process during which less restrictive measures will be used that precedes the use of restraints.

Reduction And Elimination Plan For Restraints, Isolation, or Protective Equipment

Describe or attach the plan for reducing and eventually eliminating the need for restraints.

Training

Describe or attach the plan to provide initial and on-going training for staff. Identify who will conduct the training, his/her credentials, the duration of training, and how the training will be documented.

Review

Describe or attach how the plan will be monitored, documented, and reviewed.

Individuals Having Input Into the Support Plan

Name	Relationship to Individual

Plan Review *(Asterisk indicates that signature is required.)*

Reviewer	Name	Signature	Date Reviewed (mm/dd/yyyy)
Consumer *(if not under guardianship)* *			
Guardian *(if applicable)* *			
Placing Entity *			
Provider *			
Behavior Consultant or Specialist			
Primary Physician			
Other			
Other			