DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-62608 (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 MEDICAL RESTRAINTS

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 Apparatus/Procedure

*A medical restraint is an apparatus or procedure that restricts the free, voluntary movement of a person **and** cannot be easily removed by the individual. Check "yes" if any of the following apply and provide the requested information. Identify proposed apparatus or procedure, and why these strategies are needed. Attach relevant photos, manufacturer specifications, or literature.*

☐ Yes **Medical Procedure Restraints**	Medical procedure or apparatus restrain used when necessary to accomplish diagnostic or therapeutic procedures ordered by a physician, physician's assistant, or dentist.

Procedure/ Apparatus

Purpose

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

Desired Outcome

☐ Yes **Restraints Allowing Healing**	Restraints for health-related conditions in order to allow healing of an injury. Examples of circumstances requiring healing may include lacerations, fractures, post-surgical wounds, skin ulcers, and infections.

Procedure/ Apparatus

Purpose

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

Desired Outcome

☐ Yes **Long-Term Restraints**	Restraints used for protection from injury in the presence of a chronic health condition. An example is using a safety belt to protect an individual who has severe osteoporosis and ataxia.

Procedure/ Apparatus

Purpose

Plan *(Specify where procedure or apparatus 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

Medical Condition Requiring Restraint

Describe or attach the individual's medical conditions and the situation in which they occur.

Describe or the frequency and duration of medical restraint use.

Provide written authorization by a physician which identifies the type of medical restraint ordered, the indication for its use, and the time period for its application.

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

Current and Proposed Strategies

Describe or attach a copy of the current and proposed strategies and safeguards for medical condition. Include staffing patterns, level of supervision, restrictions, or limitations. Attach the care plan, OT and PT evaluations, physician orders, and informed consent by the consumer or guardian.

Risks and Benefit

Describe a risk and benefit analysis for the use of the medical restraint.

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 the medical restraint.

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			