DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
F-62608 (Rev. 04/09)

STATE OF WISCONSIN
Chapters 50.02(2) and 51.61(1)(i), Wis. Stats.
DHS 94.10, Wis. Admin. Code

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.

Name – Consumer	Birth Date	Type of Request ☐ New ☐ Review	
Current Address – Consumer	City	State	Zip Code

Name – Guardian	Telephone Number – Guardian

Address – Guardian	City	State	Zip Code

Current Residence – Consumer

☐ Personal Residence *(same address as above)*
☐ Licensed or Certified Facility *(Provide name and address below.)*
☐ Other *(Describe and provide address below.)*

Street Address	City	State	Zip Code

Name - Facility	Facility Type
Street Address - Facility	Telephone Number

City	State	Zip Code	FAX Number

Is the consumer's proposed placement other than the current residence? ☐ Yes *(Provide name below.)* ☐ No

Name - Facility	Facility Type
Street Address - Facility	Telephone Number

City	State	Zip Code	FAX Number

Name – Agency Submitting This Request	Date Submitted

Name – Agency Contact Person	Telephone Number	FAX Number	E-mail Address

Street Address - Agency	City	State	Zip Code

DEFINITIONS

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 ***and*** a "Yes" to one of the following. Check "Yes" or "No" if the following apply.

Yes	No		
☐	☐	**Medical Procedure Restraint**	Medical procedure or apparatus restraint used when necessary to accomplish diagnostic or therapeutic procedures ordered by a physician, physician's assistant or dentist.
☐	☐	**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.
☐	☐	**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.

If the answer to the Medical Restraint *and* any of the above definitions is "Yes," continue.

PERSONAL SUMMARY

Type of Employment

Support Systems (name, address, telephone number, and relationship)

Interests

Dislikes

HEALTH CONSIDERATIONS

Diagnoses

Health Concerns

MEDICATIONS

Medication	Dose	Purpose	Prescribing Physician

HEALTH PROVIDERS

Specialty	Name	Address	Telephone
Primary Physician			
Psychiatrist			
Psychologist / Therapist			
Neurologist			
Other			
Other			
Other			

MEDICAL CONDITION REQUIRING RESTRAINT

Describe the person’s medical conditions and the situations in which they occur.

Describe the frequency and duration of 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 ALTERNATIVE STRATEGIES OR INTERVENTIONS ATTEMPTED

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

1. Strategy

Outcome

2. Strategy

Outcome

3. Strategy

Outcome

4. Strategy

Outcome

CURRENT AND PROPOSED STRATEGIES

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

RISK AND BENEFITS

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

MEDICAL RESTRAINT

Identify the proposed medical restraint 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

REDUCTION AND ELIMINATION PLAN FOR RESTRAINTS

Describe or attach a copy of the plan for reducing and eventually eliminating the need for the medical restraint.

TRAINING

Describe or attach a copy of 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 training will be documented.

REVIEW

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

SUPPORT PLAN CONTRIBUTORS / DEVELOPERS

Name	Relationship to Consumer

PLAN REVIEW

Plan Reviewed By	Name	Signature	Date Reviewed
Consumer (if not under guardianship *)			
Guardian (if applicable *)			
Placing Agency *			
Provider Agency *			
Primary Physician			
Other:			
Other:			
Other:			

* Required signatures