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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00926A (02/2017) |  | **STATE OF WISCONSIN**Wisconsin Statutes§ 51.61(1)(i)Administrative CodeDHS 94.10 |
| **REQUEST FOR USE OF MEDICAL RESTRAINTS - CLTSS** |
| 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 waiver participant and processing the request, and will not be used for any other purpose. |
| Name – Consumer      | Birth Date      | Type of Request [ ]  New [ ]  Review |
| Current Address – Consumer      | City      | State      | Zip Code      |
| Individual’s Applicable Target Group(s) (check all that apply): [ ]  CLTSS-DD [ ]  CLTSS-PD [ ] CLTSS-SED |
| Name – Parent/ Guardian      | Telephone Number – Parent/ Guardian      |
| Address – Parent/ Guardian      | City      | State      | Zip Code      |
| Current Residence – Consumer [ ]  Personal/Family Residence *(Same address as above)* [ ]  Licensed or Certified Facility, e.g., Foster Home, Adult Family Home, Shift Staff Treatment Foster Home *(Provide name and address below.)* [ ]  Other *(Describe and provide address below.)*  |
| Residence Street Address (if different from above)      | City      | State      | Zip Code      |
| 1) Name – Waiver Provider/ Agency that will use the restraint      |
| Waiver Service Type and Frequency      |
| Address – Waiver Provider/ Agency      | Telephone Number      |
| City      | State      | Zip Code      | Fax Number      |
| Email Address      |
| 2) Name – Waiver Provider Agency/ Agency that will use the restraint      |
| Waiver Service Type and Frequency      |
| Address – Waiver Provider/Agency      | Telephone Number      |
| City      | State      | Zip Code      | Fax Number      |
| Email Address      |
| County Waiver Agency Submitting This Request      | Date Submitted      |
| Contact Person/ Support & Service Coord.       | Telephone Number      | Fax Number      | Email Address      |
| Street Address - Agency      | City      | State      | Zip Code      |

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| **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*** meets ***at least 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 restraint meets the Medical Restraint Definition above *and* you answered “Yes” to one or more of the above definitions, continue.** |
| **Personal Summary** |
| Type of Daytime Activity/ School Program       |
| Support Systems (name, address, telephone number, and relationship)      |
| Interests      |
| Dislikes      |
| **Health Considerations** |
| Diagnoses      |
| Health Concerns      |
| Height:       | Weight:       |
| **Medications** |
| **Medication** | **Dose** | **Purpose** | **Prescribing Physician** |
|       |       |       |       |
|       |       |       |       |
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| **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** |
|       |       |       |       |
|       |       |       |       |
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| **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** |
|       |       |
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| **Plan Review** |
| **Plan Reviewed By** | **Name** | **Signature** | **Date Reviewed** |
| Parent /Consumer (if over age 18 and not under guardianship\*) |       |  |  |
| Guardian (if applicable\*) |       |  |  |
| Placing Agency\* |       |  |  |
| Provider Agency\* |       |  |  |
| Primary Physician\*\* |       |  |  |
| Other:       |       |  |  |
| Other:       |       |  |  |
| Other:       |       |  |  |

\* Required signatures

\*\*Required signature unless signed doctor’s order or prescription is included with application