DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00926A (02/2017)

STATE OF WISCONSIN
Wisconsin Statutes
§ 51.61(1)(i)
Administrative Code
DHS 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

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

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
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