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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-62607 (03/2017) | **STATE OF WISCONSIN**Wisconsin Statutes§§ 50.02(2) and 51.61(1)(i)WI Administrative CodeDHS § 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[ ]  New [ ]  Review | Funding Program[ ]  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** |

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| **Purpose** |

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

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| **Desired Outcome** |

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| [ ]  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** |

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| **Purpose** |

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

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| **Desired Outcome** |

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| [ ]  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** |

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| **Purpose** |

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

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| **Desired Outcome** |

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| **Personal Summary** |
| **Type of Employment/Daytime Activity** |

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

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| **Interests** |

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| **Dislikes** |

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| **Health Considerations** |
| **Diagnoses** |

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| **Health Concerns** |

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| **Current Height and Weight** |
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| **Medications** |
| **Medication** | **Dose** | **Purpose** | **Prescribing Physician** |
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| **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.** |

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

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

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

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| **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** |

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| **Outcome** |

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| **Previous Support Strategy or Intervention** |

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| **Outcome** |

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| **Previous Support Strategy or Intervention** |

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| **Outcome** |

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| **Previous Support Strategy or Intervention** |

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| **Outcome** |

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| **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.* |

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

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

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| **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.* |

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

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| **Reduction And Elimination Plan For Restraints, Isolation, or Protective Equipment** |
| *Describe or attach the plan for reducing and eventually eliminating the need for restraints.* |

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| **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.* |

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

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| **Individuals Having Input Into the Support Plan** |
| **Name** | **Relationship to Individual** |
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| **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       |       |  |       |