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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-62608 (03/2017) | **STATE OF WISCONSIN**Wisconsin Statutes§§ 50.02(2) and 51.61(1)(i)WI Administrative CodeDHS § 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[ ]  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 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 |

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| Purpose |

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

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| Desired Outcome |

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| [ ]  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 |

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

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| Desired Outcome |

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| [ ]  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 |

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| Purpose |

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| Plan *(Specify where procedure or apparatus 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      |
| **Medical Condition Requiring Restraint** |
| Describe or attach the individual’s medical conditions and the situation in which they occur. |

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| Describe or the frequency and duration of medical restraint use. |

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| 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. |

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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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| **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.* |

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| **Risks and Benefit** |
| *Describe a risk and benefit analysis for the use of the medical restraint.* |

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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 the medical restraint.* |

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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       |       |  |       |