

## REPORT OF A HOSPITAL DEATH ASSOCIATED WITH RESTRAINT OR SECLUSION

### A. Hospital Information:

Hospital Name		CCN
Address		
City	State	Zip Code
Person Filing the Report		Filer's Phone Number

### B. Patient Information:

Name		Date of Birth
Primary Diagnosis(es)		
Medical Record Number	Date of Admission	Date of Death
Cause of Death		

### C. Restraint Information (check only one):

- While in Restraint, Seclusion, or Both
- Within 24 Hours of Removal of Restraint, Seclusion, or Both
- Within 1 Week, Where Restraint, Seclusion or Both Contributed to the Patient's Death

Type (check all that apply):

- Physical Restraint    Seclusion    Drug Used as a Restraint

If Physical Restraint(s), Type (check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> 01 Side Rails                  | <input type="checkbox"/> 08 Take-downs                            |
| <input type="checkbox"/> 02 Two Point, Soft Wrist       | <input type="checkbox"/> 09 Other Physical Holds (specify): _____ |
| <input type="checkbox"/> 03 Two Point, Hard Wrist       | <input type="checkbox"/> 10 Enclosed Beds                         |
| <input type="checkbox"/> 04 Four Point, Soft Restraints | <input type="checkbox"/> 11 Vest Restraints                       |
| <input type="checkbox"/> 05 Four Point, Hard Restraints | <input type="checkbox"/> 12 Elbow Immobilizers                    |
| <input type="checkbox"/> 06 Forced Medication Holds     | <input type="checkbox"/> 13 Law Enforcement Restraints            |
| <input type="checkbox"/> 07 Therapeutic Holds           |   |

If Drug Used as Restraint:

Drug Name	Dosage
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