



All Fields Required

INDIVIDUAL INFORMATION

1. Individual Name or TABS ID: FIRST = _____ LAST = _____ TABS ID# = _____

EVENT INFORMATION

2. IRMA Master Incident Number (if available/applicable): _____

PROGRAM INFORMATION

3. Program/Site: _____

4. Program Address: _____

5. Program Type:

- Autism Unit, Center for Intensive Treatment Unit (CIT), Clinic, Community Residence (CR), Day Habilitation-Site Based, Day Treatment, Developmental Center (DC), Employment/Work Site, Family Care Home, Free Standing Respite (FSR), Intermediate Care Facility (ICF) – Community Based, Individualized Residential Alternative (IRA), Local Intensive Treatment Unit (LIT), Multiple Disabled Unit (MDU), Private School, Regional Intensive Treatment Unit (RIT), Special Behavioral Unit (SBU), Small Residential Unit (SRU)

6. Location: [X] only one location unless additional interventions result in other locations used. If multiple locations are used, check "Other" and explain.

- Attic, Back Yard, Basement, Bathroom, Bedroom, Dining Room, Other, Elevator, Foyer, Front Yard, Garage, Hallway, Kitchen, Laundry Room, Living Room, Loading Dock, Lunch Room, Off Facility Property, Office, Parking Lot, Program Room, Recreation Area, Sidewalk, Staircase, Swimming Pool, Time-out Room, Treatment Room, Vehicle, Work Area

RESTRICTIVE PHYSICAL INTERVENTION INFORMATION

7. Select the most Restrictive SCIP-R Technique Used (Check only one):

- One Person Take-Down, One Person Take-Down to Side Control, One Person Take-Down to Seated Control, Seated Control to Supine Control, Seated Control to Two to Three Person Supine Control, Two Person Take Down, Two Person Take-Down to Supine Control, Two Person Take-Down to Two to Three Person Supine Control, Two to Three Person Supine Control, OPWDD Approved Technique: Four Person Supine Control [Intensive Treatment Option (ITO)], Five to Six Person Supine Control (ITO's only), Individual-Specific restrictive technique: e.g. lift/carry, 4 person supine in a Non-ITO setting, etc. Please explain.

8. Usage of Physical Intervention: [X] all that apply [] Part of Behavior Plan [] Emergency Basis

9. Date Physical Intervention Used: _____

10. Time Physical Intervention Started: (HH MM) _____ am / pm Ended: (HH MM) _____ am / pm

11. Duration of Intervention: _____ If it exceeds 20 minutes, a 147 form must be filed in IRMA

12. Reason for Physical Intervention: [X] all that apply

- Harming Others, Harming Self, Person in an unsafe location, Other (explain):

Other Reason for Physical Intervention: _____

MEDICAL INFORMATION

13. **Body Check Performed?** Yes No

a. If yes, Name of staff person conducting body check:

FIRST= _____ LAST= _____

b. TITLE:

- | | |
|---|--|
| <input type="checkbox"/> Direct Support Professional | <input type="checkbox"/> Nurse Practitioner (NP) |
| <input type="checkbox"/> Direct Support Professional SUPERVISOR | <input type="checkbox"/> Registered Nurse (RN) |
| <input type="checkbox"/> Residential Manager/House Director | <input type="checkbox"/> Physician Assistant (PA) |
| <input type="checkbox"/> Classroom Aide/Assistant | <input type="checkbox"/> Behavior Specialist/Assistant |
| <input type="checkbox"/> Classroom TEACHER | <input type="checkbox"/> Licensed Psychologist |
| <input type="checkbox"/> Classroom SUPERVISOR | <input type="checkbox"/> Clinician |
| <input type="checkbox"/> Licensed Practical Nurse (LPN) | <input type="checkbox"/> Other _____ |

c. If no - What is the reason? Refused Unknown Called 911 Transported to ER
 Emergent Medical Needs Supersedes Body Check

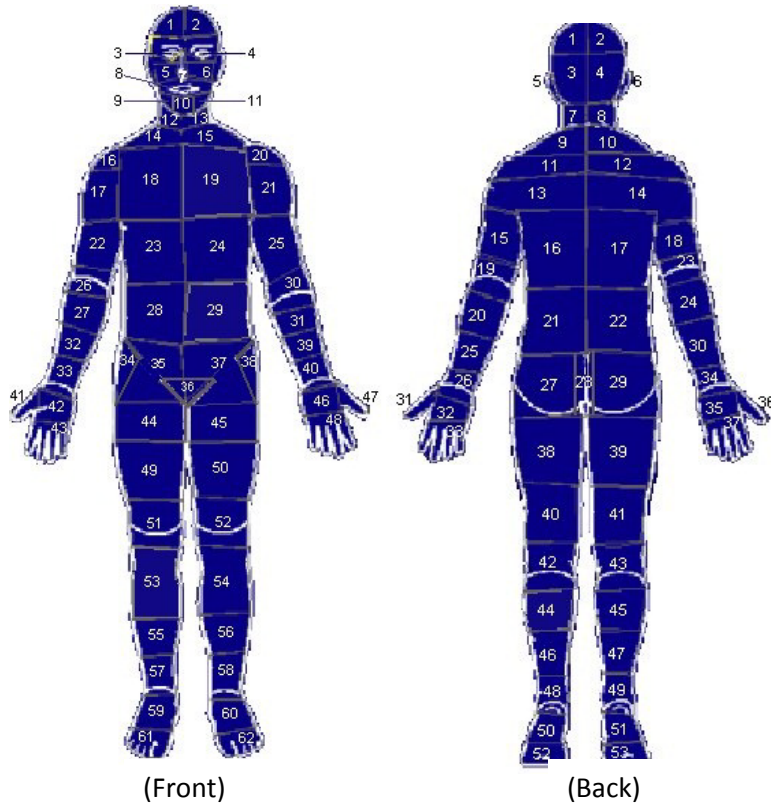
14. **Injury:** Was there an Injury?

Yes *If yes, all the injuries from the list below* No Unknown

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Redness | <input type="checkbox"/> CONCUSSION | <input type="checkbox"/> LACERATION W/SUTURES |
| <input type="checkbox"/> Bruise/Contusion | <input type="checkbox"/> Scratch | <input type="checkbox"/> DISLOCATION | <input type="checkbox"/> LOSS OF CONSCIOUSNESS |
| <input type="checkbox"/> Hematoma | <input type="checkbox"/> Skin Reaction | <input type="checkbox"/> FRACTURE | |
| <input type="checkbox"/> Laceration without Sutures | <input type="checkbox"/> Swelling | <input type="checkbox"/> INTERNAL INJURIES | |
| <input type="checkbox"/> Puncture | <input type="checkbox"/> Sprain | <input type="checkbox"/> OTHER (<i>only if it meets the Part 624 definition of an injury</i>) | |

If any of the injuries selected are CAPITALIZED, a 147 form must be filed in IRMA.

15. Indicate the Injury Location for the Individual by number(s) found on the



a. Front Body Diagram: _____

b. Back Body Diagram: _____

STAFF INFORMATION

16. Please list up to six (6) staff involved in the physical intervention. Use titles from #13.b:

Staff 1:	_____	_____	_____
	First Name	Last Name	Title
Staff 2:	_____	_____	_____
	First Name	Last Name	Title
Staff 3:	_____	_____	_____
	First Name	Last Name	Title
Staff 4:	_____	_____	_____
	First Name	Last Name	Title
Staff 5:	_____	_____	_____
	First Name	Last Name	Title
Staff 6:	_____	_____	_____
	First Name	Last Name	Title

17. Was Staff Injured as a Result of the Physical Intervention?

- Yes No Yes, Multiple Staff Injured

MEDICATION ADMINISTRATION INFORMATION N/A

18. Date Medication Administered: _____

19a. PRN Medication STAT Medication

20a. Medication Name: _____ Dose: _____ Route: (PO/IM) _____
 (Refer to attached chart for medication name, dose and route.)

21a. Usage of Restrictive Intervention: all that apply Part of Behavior Plan Emergency Basis

22a. Time Medication Administered: (HH MM) _____ am / pm

23a. Reason Medication was administered: all that apply: Harming Others Harming Self Other (explain):

Other Reason for Medication Administered: _____

19b. PRN Medication STAT Medication

20b. Medication Name: _____ Dose: _____ Route: (PO/IM) _____
 (Refer to attached chart for medication name, dose and route.)

21b. Usage of Restrictive Intervention: all that apply Part of Behavior Plan Emergency Basis

22b. Time Medication Administered: (HH MM) _____ am / pm

23b. Reason Medication was administered: all that apply: Harming Others Harming Self Other (explain):

Other Reason for Medication Administered: _____

19c. PRN Medication STAT Medication

20c. Medication Name: _____ Dose: _____ Route: (PO/IM) _____
 (Refer to attached chart for medication name, dose and route.)

21c. Usage of Restrictive Intervention: all that apply: Part of Behavior Plan Emergency Basis

22c. Time Medication Administered: (HH MM) _____ am / pm

23c. Reason Medication was administered: all that apply: Harming Others Harming Self Other (explain):

Other Reason for Medication Administered: _____

