DATA COLLECTION FOR INCIDENT: RESTRAINT OTHER

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AUTISM SERVICES UNIT
SFN 60607 (3-2014)

Entered By	
Entry Date	Entry Time

*** Required Fields**

Other Type*

☐ Chemical

Medication Name	Dosage
Name of Physician	Title
Drug Ordered ☐ PRN ☐ Emergency Order	

☐ Physical

☐ Mechanical

☐ Other (specify): _____

Begin Time* ☐ a.m. ☐ p.m.	End Time* ☐ a.m. ☐ p.m.	End Date

Specific Location

☐ Living Room ☐ Bedroom ☐ Dining Room ☐ Kitchen ☐ Bathroom ☐ Hallway

☐ Staircase ☐ Activity Area ☐ Recreation Area ☐ Outdoors ☐ Unknown

☐ Other (specify): _____

Restraint Summary

Was a witness present? ☐ Yes ☐ No - If yes, complete the Witness Information Section below

WITNESS INFORMATION

Name of Witness		Telephone Number	
Address	City	State	ZIP Code
Witness Comments			

I certify that I was a witness to the injury incident:

Signature of Witness	Date	Time ☐ a.m. ☐ p.m.