



Restraint/Isolation Report

Identifiable Information

Date:	Student First Name:	<input type="checkbox"/>	GenEd only
Start time of incident:	Student Last Name:	<input type="checkbox"/>	504
End time of incident:	Student ID	<input type="checkbox"/>	IEP
School/Program:	DOB:	<input type="checkbox"/>	BIP and/or ERP

Incident Information

What happened before the behavior occurred? \_\_\_\_\_

\_\_\_\_\_

What did the student's behavior look like? \_\_\_\_\_

\_\_\_\_\_

Describe the imminent likelihood of serious harm to self or others. \_\_\_\_\_

\_\_\_\_\_

Incident Minimization and De-Escalation

Incident Minimization	Incident Minimization Cont.	Steps of De-Escalation
<input type="checkbox"/> Manage Triggers/Space	<input type="checkbox"/> Supportive Guide	<input type="checkbox"/> Help Method
<input type="checkbox"/> Safety/Moveable Stance	<input type="checkbox"/> Safe Turn	<input type="checkbox"/> Prompt Method
<input type="checkbox"/> Elbow/Shoulder/Knee Check	<input type="checkbox"/> Pad Blocking	<input type="checkbox"/> Wait Method
<input type="checkbox"/> Triad Tactic	<input type="checkbox"/> Releases: _____	<input type="checkbox"/> Other: _____

Restraint, Escort, or Isolation

Escort: Y N If yes, select:	Restraint: Y N If yes, select:	Isolation: Y N If yes, location:
<input type="checkbox"/> 1-Person Forward Transport	<input type="checkbox"/> 1-Person Stability Hold	<input type="checkbox"/> Bus/Car/Other Vehicle
<input type="checkbox"/> 2-Person Forward Transport	<input type="checkbox"/> 2-Person Stability Hold	<input type="checkbox"/> Classroom
<input type="checkbox"/> Reverse Transport	<input type="checkbox"/> Floor Seated Stability Hold	<input type="checkbox"/> Closet, Locker Room, or other non-classroom space
Duration: From: _____ To: _____	<input type="checkbox"/> Chair Stability Hold	<input type="checkbox"/> Designated Isolation Room
Total Time: _____	<input type="checkbox"/> Leg Wrap with Holds	<input type="checkbox"/> Offices including nurse, counselor, main, admin
Transitions: Y N If yes, select:	<input type="checkbox"/> Hip-Sit (Vehicle)	
<input type="checkbox"/> Floor Drop	<input type="checkbox"/> 1-Person Seated Hold (Vehicle)	
<input type="checkbox"/> Lift to Standing	Duration: From: _____ To: _____	Duration: From: _____ To: _____
<input type="checkbox"/> Standing to Seated	Total Time: _____	Total Time: _____

Details

Staff members (name and title) administering restraint/escort/isolation? \_\_\_\_\_

\_\_\_\_\_

Physical injury to students: Y N If yes, list how many and who: \_\_\_\_\_ If yes, describe any medical care: \_\_\_\_\_

Physical injury to staff: Y N \_\_\_\_\_

Reporting/Debrief

Principal/Administrator notified within 24 hours: Y N Report sent to District office within 48 hours: Y N

Parent/Guardian: Notified within 24 hours: Y N Date/Time: \_\_\_\_\_ By: \_\_\_\_\_

Written Notification within 48 hours: Y N Method (circle one) E-mail Student U.S. Mail Date: \_\_\_\_\_

Reviewed the incident with the student and the parent/guardian within 48 hours? Y N Documented student debrief if applicable? Y N

Within 48 hours, you've reviewed the incident with relevant team members and if necessary any supporting plans (IEP, BIP, ERP etc), and determined if any additional training or changes is needed? Y N Date/Time: \_\_\_\_\_ If 3rd incident within trimester, completed additional debrief form? Y N

Designation

Signature/Staff Member	Date	Signature/Principal	Date	Signature/Program Director	Date
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