VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

COMMUNITY SECLUSION AND RESTRAINT REPORTING FORM

Name of Licensed Organization_____DATE_____

Name of Program_____

Name and Telephone Number of Contact Person (person who completed the form)

_____

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Date Initiated	Type of Procedure	Rationale	Duration
1/13/12	Restraint	Behavioral	10 min
2/3/12	Restraint	Protective	3 weeks
4/21/12	Seclusion	Behavioral	280 min
5/1/12	Restraint	Medical	3 days
	SAMPLE		

Please follow the reporting form requirements when completing the form. If you have any questions, please call or email Mary Clair O'Hara in the Office of Clinical Quality and Risk Management using the information below.

THE FORM IS DUE BY FEBRUARY 15.

Mail, fax or email to the following:

Virginia Department of Behavioral Health and Developmental Services
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