Form Approved
OMB No. 0938-1210

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)*:

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

If Drug Used as Restraint:

Drug Name	Dosage