County Of Orange Health Care Agency
Behavioral Health Services

Seclusion/Restraint Advisement

______________________________ provides a safe environment for all of our patients, families and staff.
(Name of Facility)

Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member or others from harm. If seclusion and/or restraint is necessary, you will be under continuous observation with frequent assessments and released as soon as criteria for safety are met
(42 CFR § 482.13).

If you are aware of events that you think may trigger this behavior and know of ways that can help avoid high risk behaviors, please inform the staff in assisting to complete the information below.

These following situations can trigger my emotions or behaviors:

- ☐ Being Touched
- ☐ Lack of Privacy
- ☐ Loneliness
- ☐ Loud Noises
- ☐ Being Isolated
- ☐ People in uniform
- ☐ Someone standing too close
- ☐ Redirection from staff
- ☐ Yelling
- ☐ Not being listened to
- ☐ Authority figure saying "No"
- ☐ Other people being out of control
- ☐ Someone calling you names
- ☐ ______________________________
- ☐ ______________________________

These warning signs are noticeable when I'm upset:

- ☐ Sweating
- ☐ Clenching fist
- ☐ Pacing
- ☐ Isolating/Staying in my room
- ☐ Hurting myself
- ☐ Red face
- ☐ Rocking back and forth
- ☐ Sleeping a lot
- ☐ Swearing
- ☐ Loud voice
- ☐ Breathing hard
- ☐ Clenching my teeth
- ☐ Bouncing my legs
- ☐ ______________________________
- ☐ ______________________________

These things can help me to calm down or regain control:

- ☐ Time alone in my room
- ☐ Talking to someone
- ☐ Doing crafts/activities
- ☐ Talking positively to yourself
- ☐ Writing in a diary/journal
- ☐ Watching television
- ☐ Deep breathing exercise
- ☐ Wrapping up in a blanket
- ☐ Listening to music
- ☐ Reading
- ☐ Being alone in a quiet place
- ☐ A change in scenery
- ☐ Thinking of something pleasant
- ☐ Physical exercise
- ☐ Taking a hot shower
- ☐ Medication: ____________________
- ☐ ______________________________
- ☐ ______________________________

Have you ever been physically or sexually abused? Please explain:

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Do you have any pre-existing medical conditions/physical disabilities/limitations? Please explain:

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SIGNATURES

☐ Advisement was not completed at time of admission. Attempted by: ______________________________

Reason: ______________________________ Date: ______________________ Time: __________

____ ______________________
(Signature of Patient) (Date & Time)

____ ______________________
(Signature of Facility Staff) (Date & Time)

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