



Restrictive Intervention Application (RIA) Data Form

All Fields Required

INDIVIDUAL INFORMATION

1. Individual Name or TABS ID: **FIRST** = _____ **LAST** = _____ **TABS ID#**= _____

EVENT INFORMATION

2. IRMA Master Incident Number (if available/applicable): _____

PROGRAM INFORMATION

3. Program/Site: _____

4. Program Address: _____

5. Program Type:

- | | |
|--|---|
| <input type="checkbox"/> Autism Unit | <input type="checkbox"/> Free Standing Respite (FSR) |
| <input type="checkbox"/> Center for Intensive Treatment Unit (CIT) | <input type="checkbox"/> Intermediate Care Facility (ICF) – Community Based |
| <input type="checkbox"/> Clinic | <input type="checkbox"/> Individualized Residential Alternative (IRA) |
| <input type="checkbox"/> Community Residence (CR) | <input type="checkbox"/> Local Intensive Treatment Unit (LIT) |
| <input type="checkbox"/> Day Habilitation-Site Based | <input type="checkbox"/> Multiple Disabled Unit (MDU) |
| <input type="checkbox"/> Day Treatment | <input type="checkbox"/> Private School |
| <input type="checkbox"/> Developmental Center (DC) | <input type="checkbox"/> Regional Intensive Treatment Unit (RIT) |
| <input type="checkbox"/> Employment/Work Site | <input type="checkbox"/> Special Behavioral Unit (SBU) |
| <input type="checkbox"/> Family Care Home | <input type="checkbox"/> Small Residential Unit (SRU) |

6. Location: only one location unless additional interventions result in other locations used.

If multiple locations are used, check "Other" and explain.

- | | | | | |
|---------------------------------------|-------------------------------------|--|--|---|
| <input type="checkbox"/> Attic | <input type="checkbox"/> Elevator | <input type="checkbox"/> Laundry Room | <input type="checkbox"/> Parking Lot | <input type="checkbox"/> Time-out Room |
| <input type="checkbox"/> Back Yard | <input type="checkbox"/> Foyer | <input type="checkbox"/> Living Room | <input type="checkbox"/> Program Room | <input type="checkbox"/> Treatment Room |
| <input type="checkbox"/> Basement | <input type="checkbox"/> Front Yard | <input type="checkbox"/> Loading Dock | <input type="checkbox"/> Recreation Area | <input type="checkbox"/> Vehicle |
| <input type="checkbox"/> Bathroom | <input type="checkbox"/> Garage | <input type="checkbox"/> Lunch Room | <input type="checkbox"/> Sidewalk | <input type="checkbox"/> Work Area |
| <input type="checkbox"/> Bedroom | <input type="checkbox"/> Hallway | <input type="checkbox"/> Off Facility Property | <input type="checkbox"/> Staircase | |
| <input type="checkbox"/> Dining Room | <input type="checkbox"/> Kitchen | <input type="checkbox"/> Office | <input type="checkbox"/> Swimming Pool | |
| <input type="checkbox"/> Other: _____ | | | | |

RESTRICTIVE PHYSICAL INTERVENTION INFORMATION

7. Select the *most* Restrictive SCIP-R Technique Used (Check only one):

- | | |
|---|--|
| <input type="checkbox"/> One Person Take-Down | <input type="checkbox"/> Two Person Take-Down to Two to Three Person Supine Control |
| <input type="checkbox"/> One Person Take-Down to Side Control | <input type="checkbox"/> Two to Three Person Supine Control |
| <input type="checkbox"/> One Person Take-Down to Seated Control | <input type="checkbox"/> OPWDD Approved Technique: |
| <input type="checkbox"/> Seated Control to Supine Control | <input type="radio"/> Four Person Supine Control [Intensive Treatment Option (ITO)] |
| <input type="checkbox"/> Seated Control to Two to Three Person Supine Control | <input type="radio"/> Five to Six Person Supine Control (ITO's only) |
| <input type="checkbox"/> Two Person Take Down | <input type="radio"/> Individual-Specific restrictive technique: e.g. lift/carry, 4 person supine in a Non-ITO setting, etc. Please explain. |
| <input type="checkbox"/> Two Person Take-Down to Supine Control | |

8. Usage of Physical Intervention: all that apply Part of Behavior Plan Emergency Basis

9. Date Physical Intervention Used: _____

10. Time Physical Intervention **Started:** (HH MM) _____ am / pm **Ended:** (HH MM) _____ am / pm

11. Duration of Intervention: _____ **If it exceeds 20 minutes, a 147 form must be filed in IRMA**

12. Reason for Physical Intervention: all that apply

- | | | | |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> Harming Others | <input type="checkbox"/> Harming Self | <input type="checkbox"/> Person in an unsafe location | <input type="checkbox"/> Other (explain): |
|---|---------------------------------------|---|---|

Other Reason for Physical Intervention: _____

MEDICAL INFORMATION

13. **Body Check Performed?** Yes No

a. If yes, Name of staff person conducting body check:

FIRST= _____ LAST= _____

b. TITLE:

- | | |
|---|--|
| <input type="checkbox"/> Direct Support Professional | <input type="checkbox"/> Nurse Practitioner (NP) |
| <input type="checkbox"/> Direct Support Professional SUPERVISOR | <input type="checkbox"/> Registered Nurse (RN) |
| <input type="checkbox"/> Residential Manager/House Director | <input type="checkbox"/> Physician Assistant (PA) |
| <input type="checkbox"/> Classroom Aide/Assistant | <input type="checkbox"/> Behavior Specialist/Assistant |
| <input type="checkbox"/> Classroom TEACHER | <input type="checkbox"/> Licensed Psychologist |
| <input type="checkbox"/> Classroom SUPERVISOR | <input type="checkbox"/> Clinician |
| <input type="checkbox"/> Licensed Practical Nurse (LPN) | <input type="checkbox"/> Other _____ |

c. If no - What is the reason? Refused Unknown Called 911 Transported to ER
 Emergent Medical Needs Supersedes Body Check

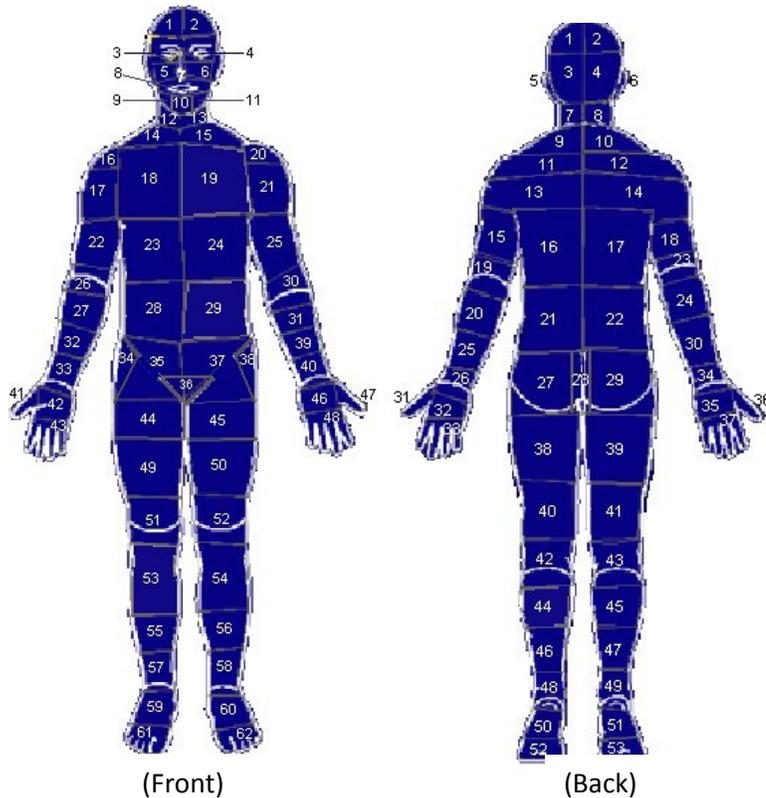
14. **Injury:** Was there an Injury?

Yes *If yes, all the injuries from the list below* No Unknown

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Redness | <input type="checkbox"/> CONCUSSION | <input type="checkbox"/> LACERATION W/SUTURES |
| <input type="checkbox"/> Bruise/Contusion | <input type="checkbox"/> Scratch | <input type="checkbox"/> DISLOCATION | <input type="checkbox"/> LOSS OF CONSCIOUSNESS |
| <input type="checkbox"/> Hematoma | <input type="checkbox"/> Skin Reaction | <input type="checkbox"/> FRACTURE | |
| <input type="checkbox"/> Laceration without Sutures | <input type="checkbox"/> Swelling | <input type="checkbox"/> INTERNAL INJURIES | |
| <input type="checkbox"/> Puncture | <input type="checkbox"/> Sprain | <input type="checkbox"/> OTHER (<i>only if it meets the Part 624 definition of an injury</i>) | |

If any of the injuries selected are CAPITALIZED, a 147 form must be filed in IRMA.

15. Indicate the Injury Location for the Individual by number(s) found on the



a. Front Body Diagram: _____

b. Back Body Diagram: _____

STAFF INFORMATION

16. Please list up to six (6) staff involved in the physical intervention. Use titles from #13.b:

Staff 1:	_____	_____	_____
	First Name	Last Name	Title
Staff 2:	_____	_____	_____
	First Name	Last Name	Title
Staff 3:	_____	_____	_____
	First Name	Last Name	Title
Staff 4:	_____	_____	_____
	First Name	Last Name	Title
Staff 5:	_____	_____	_____
	First Name	Last Name	Title
Staff 6:	_____	_____	_____
	First Name	Last Name	Title

17. Was Staff Injured as a Result of the Physical Intervention?

- Yes No Yes, Multiple Staff Injured

MEDICATION ADMINISTRATION INFORMATION N/A

18. Date Medication Administered: _____

19a. PRN Medication STAT Medication

20a. Medication Name: _____ Dose: _____ Route: (PO/IM) _____
 (Refer to attached chart for medication name, dose and route.)

21a. Usage of Restrictive Intervention: *all that apply* Part of Behavior Plan Emergency Basis

22a. Time Medication Administered: (HH MM) _____ am / pm

23a. Reason Medication was administered: *all that apply*: Harming Others Harming Self Other (explain):
 Other Reason for Medication Administered: _____

19b. PRN Medication STAT Medication

20b. Medication Name: _____ Dose: _____ Route: (PO/IM) _____
 (Refer to attached chart for medication name, dose and route.)

21b. Usage of Restrictive Intervention: *all that apply* Part of Behavior Plan Emergency Basis

22b. Time Medication Administered: (HH MM) _____ am / pm

23b. Reason Medication was administered: *all that apply*: Harming Others Harming Self Other (explain):
 Other Reason for Medication Administered: _____

19c. PRN Medication STAT Medication

20c. Medication Name: _____ Dose: _____ Route: (PO/IM) _____
 (Refer to attached chart for medication name, dose and route.)

21c. Usage of Restrictive Intervention: *all that apply*: Part of Behavior Plan Emergency Basis

22c. Time Medication Administered: (HH MM) _____ am / pm

23c. Reason Medication was administered: *all that apply*: Harming Others Harming Self Other (explain):
 Other Reason for Medication Administered: _____

