Nebraska Medicaid Restraint and Seclusion Report

Restraint and Seclusion that occurred while in the care of a behavioral health Psychological Residential Treatment Facility or Therapeutic Group Home setting.

Instructions: Submit all pages of this form with as much information as possible within the required reporting timeframes.

- **Submit this form by:**
  - Email — NTCQUALITY@CENTENE.COM

Provider Type: ☐ Psychological Residential Treatment Facility ☐ Therapeutic Group Home

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Reporting Facility:

Facility National Provider Identifier: _____ Facility Name: _____
NPI of the facility in which the restraint/seclusion took place

Facility Nebraska Medicaid ID: _____
Medicaid ID of the Facility in which the restraint/seclusion took place

Facility Address: _____ City: _____ State: _____ Zip:_____

Phone #:_____

Reporter Name: _____ Title: _____ Email: _____

Reporting Provider:

National Provider Identifier: _____ Provider Name: _____
NPI of provider that ordered the restraint/seclusion

Provider Nebraska Medicaid ID: _____
Medicaid provider ID number

Medicaid Member:

Medicaid State No.:_____ Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip:_____

Date of Birth: _____ Member's Gender: ☐ Male ☐ Female

Incident Information:

Date of Incident: _____ Time of Incident: _____ ☐ a.m. ☐ p.m. ☐ unknown

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Restraint Type: ☐ Physical ☐ Medicinal ☐ None
☐ Other_____

Physical Restraint Description (Include Who, What, When, Where, and How in a clear concise manner noting short description of the physical restraint used):
REQUIRED IF AND ONLY IF: "Restraint Type" is "Physical"

_____

_____

_____

_____

_____

Other Restraint Description (Include Who, What, When, Where, and How in a clear concise manner noting short description of the 'Other' restraint used):
REQUIRED IF AND ONLY IF: "Restraint Type" is "Other"

_____

_____

_____

_____

_____

Medicinal Restraint (1) Generic name of medication: _____
REQUIRED IF AND ONLY IF: "Restraint Type" is "Medicinal"
Mg of Restraint (1) : _____
Mg of the medication used for restraint as number

Medicinal Restraint (2) Generic name of medication: _____
Mg of Restraint (2) : _____
Mg of the medication used for restraint as number

Medicinal Restraint (3) Generic name of medication: _____
Mg of Restraint (3) : _____
Mg of the medication used for restraint as number

Secluded:
Was the member secluded: ☐ Yes ☐ No
Secluded with Clothing Removed: ☐ Yes ☐ No
Did the seclusion include the removal of the members clothing?

INJURED

Injured: ☐ ***Yes** ☐ No
Was the member injured?

Injury Description (Short description of the injury):
REQUIRED IF AND ONLY IF: "Injured" is "Yes"

_____

_____

_____

_____

_____

Bone(s) Broken: ☐ Yes ☐ No
Did the member break bone(s)?

Abrasion(s): ☐ Yes ☐ No
Did the member receive any abrasion(s)?

Cut(s): ☐ Yes ☐ No
Did the member receive any cut(s)?

Scratch(es): ☐ Yes ☐ No
Did the member receive any scratch(es)?

Redness of Skin: ☐ Yes ☐ No
Did the restraint result in any redness of skin?

Swelling: ☐ Yes ☐ No
Did the restraint result in any swelling?

Bruises: ☐ Yes ☐ No
Did the member receive any bruise(s)?

***REQUIRED IF:** "Injured" is "Yes" to complete Critical Incident form.