## **REPORT OF A HOSPITAL DEATH ASSOCIATED WITH RESTRAINT OR SECLUSION**

A. Hospital Information:		
Hospital Name		CCN
Address		
	F	
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
Course of Dooth		

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				
$\Box$ 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	🗆 08 Take-downs			
🗆 02 Two Point, Soft Wrist	O9 Other Physical Holds (specify):			
🗆 03 Two Point, Hard Wrist	10 Enclosed Beds			
🗆 04 Four Point, Soft Restraints	11 Vest Restraints			
O5 Four Point, Hard Restraints	12 Elbow Immobilizers			
O6 Forced Medication Holds	13 Law Enforcement Restraints			
O7 Therapeutic Holds				
If Drug Used as Restraint:				
Drug Name	Dosage			