McLaren
FLINT

SECLUSION/RESTRAINT DEBRIEFING
BEHAVIORAL HEALTH

Event Summary: Must be completed within 24 hours of event Event Date/Time:_____

Individuals present for debriefing:

_____
_____

Reason for use of seclusion/restraint:

_____
_____

Behavior necessary to discontinue seclusions/restraints:

_____
_____

Anything that could have been done different:

_____
_____

Patient's response to how his/her physical needs were met and addressed during event:

_____
_____

Patient's response to how his/her emotional needs were met and addressed during event:

_____
_____

Patient's response to privacy were addressed during event:

_____
_____

Counseling provided to patient from trauma relating to event:

_____
_____

Additional Information:

_____
_____

Employee Signature:_____Date:_____Time:_____

Employee printed name:_____Role:_____

White Copy: Chart
Yellow Copy: Office

SECLUSION/RESTRAINT DEBRIEFING

M-17391 (6.19)

700b

PT.

MR.#/P.M.

DR.