Name:       DOB:       Span Dates:       to

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| INFORMED CONSENT TO RESTRICTIVE SUPPORT STRATEGIES |
| I,      , give permission to any/all of my/his/her staff to use the following restrictive  (printed name of individual or guardian)support strategies with:  (printed name of individual)My signature below also indicates that I give permission for FCBDD Human Rights Committee (HRC) to review the paperwork that documents the details of restrictive support strategies for me/my ward. HRC team members have been trained on the behavioral support rule, confidentiality, person-centered planning, trauma-informed care, and other applicable areas.  |
| Specify all that apply at this time (category & specific type; i.e., manual restraint/baskethold, rights restriction/locked knives):\*\* If any type of restraint or time-out is recommended, I understand that medical, emotional, and environmental conditions have been considered and there are no reasons why this type of support should not be used with/for me/my ward during span dates specified below. |
| I give permission for the use of the above restrictive support strategies during the following dates:      through       **OR**       through       (date signed) (last day of current ISP span) (first day of next ISP span) (last day of next ISP span) |
| 1. How the restrictive support strategies are to help:
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| 1. How progress will be reviewed:
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| 1. Risks of suggested restrictives:
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| 1. Other options to restrictive supports:
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| I have had the chance to ask questions regarding the restrictive support strategies listed above and my questions have been answered by      . I can contact this person if I have more questions.  (print name/phone # of monitor of restrictive supports)He/she has explained how these supports will help me AND what might go wrong or could hurt me, and other things we could do instead. Things in my life (relationships, places, physical & mental health, what is important to/for me) that may be related to my needs have all been considered in choosing my supports.  I know that my supports may not work exactly the way that I and others plan. I know I can change my mind about these supports if I want. If I change my mind and do not want these supports, I need to tell an appropriate staff person. If I change my mind, I will not lose services without my providers first talking to me.  I understand this form. A copy will be included in my ISP.  |
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|  (Individual) (Date Signed) |
|  (Parent/Guardian) (Date Signed) |

 (Witness) (Date Signed)

I believe that the use of the above restrictive supports with       will serve his/her best interests, and I have talked with him/her about this. I am aware of his/her skills, needs and wants.

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(Advocate, e.g., Service Coordinator, or other Representative, if no Parent or Guardian) (Date Signed)