QUARTERLY SECLUSION AND/OR RESTRAINT REPORTING FORM

TO: SCDHHS Division of Behavioral Health

Name of Facility:

Name of Ordering Provider:

Name of Reporting Staff:

Facility Address:

Facility Telephone: (xxx) xxx-xxxx

Reporting Data

Quarter (list specific months):

Resident Name	Medicaid ID	Staff Involved	Date and Time of Intervention	Location of Intervention	Type of Intervention (Seclusion or Restraint)	Reason for Intervention

Reports must be submitted electronically in a secure format to behavioralhealth004@scdhhs.gov. Deadline for submitting reports is 30 days after the end of the quarter.