RECORD OF REGULATED RESTRICTIVE PRACTICE

Participant Name: **Date:** **Time:** **Place:**

Description of Regulated Restrictive Practice	
Impact on the participant	
Impact on another person (if relevant)	
Injury received and who to?	

Why was the RRP used?			
What led to the use of the RRP?			
Names and contact details of persons involved	Name:	Address:	Phone:
	Name:	Address:	Phone:
Name and contact details of Witnesses	Name:	Address:	Phone:
	Name:	Address:	Phone:
Actions taken in response to RRP			

Were other options considered or attempted?	
Action take leading up to RRP	
Strategies used to prevent the use of RRP	

This form when completed must be retained for seven (7) years by Provider

Name of person completing this form: Signature:

Date:

Managers Name: Signature: