* 5 0 0 1 0 *

ACT Health

Seclusion Form

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Gender: _____

Date …. / …. / …… Inpatient unit: ……

Reasons for seclusion: Outline behaviours and events:

……

……

……

……

Nursing interventions used prior to seclusion

……

……

……

……

☐ The person has been informed of the seclusion process.

Dedicated seclusion room used? ☐ Yes ☐ No ☐ Other ……

Seclusion authorised for number of hours: ……

Seclusion initiated by: …….. ……

Seclusion Commenced: Date: ….. / ….. / ….. Time: …….

Seclusion Ceased: Date: ….. / ….. / ….. Time: …….

Consultant Psychiatrist contacted: Time: ……. Name of Psychiatrist: ……

PRN Medication used prior to seclusion? ☐ Yes ☐ No Details (Medication/Dose/Time given)

……

……

……

Was the consumer observed constantly? ☐ Or at Intervals (max of 10 mins) ☐ ……

All necessary clinical documentation has been fully completed? ☐

Comments

……

……

……

……

……

Notice of Seclusion faxed to Public Advocate. Date: ….. / ..... / …..... Time: ……

Print Name: …….. Signature ……. Shift Team Leader

It is a requirement of the Mental Health Act 2015 that the Public Advocate of the ACT is notified in writing of seclusion within 12 hours (fax: 6207 0688)