



### NOTICE REGARDING RESTRICTED RIGHTS OF INDIVIDUALS

Reference: 405 ILCS 5/2-102, 2-103, 2-104, 2-107, 2-108, 2-109, 2-200, and 22-201

Name: \_\_\_\_\_ I.D.: \_\_\_\_\_ Unit: \_\_\_\_\_ Facility: \_\_\_\_\_

#### **PART I (Physical Hold/Restraint/Seclusion/Emergency Medication Restrictions)**

On \_\_\_\_\_ at \_\_\_\_\_  
Date Time

Individual was:  placed in physical hold  placed in restraint  placed in seclusion  administered emergency medication

Reason(s) for the identified restrictions(s):

**In accordance with the Mental Health and Developmental Disabilities code, the individual designated his or her preference for emergency intervention if circumstances arise as indicated below (check one):**

- The individual indicated "No Preference" for emergency intervention(s)
- The individual preference was utilized (see Treatment Plan)
- The individual preference was **NOT** utilized for the following reason(s):

#### **PART II (Other Restrictions)**

From: \_\_\_\_\_ to: \_\_\_\_\_  
Date and Time Date and Time

**Had a restriction placed on certain rights (checked and explained below):**

- To refuse medical services - x-ray  To refuse medical services - laboratory specimens  To retain personal property
- To refuse other medical services  To refuse search of person or living area  Other: \_\_\_\_\_
- To manage personal hygiene  To refuse dental services
- To be allowed communication via:  Telephone  Mail  Visitation  Other: \_\_\_\_\_

Reason(s) for the identified restrictions(s) include:

#### **PART III (Applies to Parts I and II)**

**A copy of this notice was given to the individual in:**  English  Spanish  Other: \_\_\_\_\_

Individual wished no one be notified of this Notice (**Exception: Guardian must always be notified**)

Individual wished Guardian and/or Designee notified as indicated below:

Guardian: \_\_\_\_\_ Address: \_\_\_\_\_

Designee: \_\_\_\_\_ Address: \_\_\_\_\_

**I certify that I have completed this form. Copies of this notice were given to the individual, mailed to all indicated individuals, and placed in his or her medical record.**

Date/Time: \_\_\_\_\_ Signature: \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_



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### **NOTICE REGARDING RESTRICTED RIGHTS OF INDIVIDUAL**

#### **Additional Notice to Individual**

**If your right to mail a letter or package, have visitors, or use the telephone is restricted, you have the right to have the facility notify the affected parties.**

**When the restriction is over, you also have the right to have facility notify the affected parties.**

**You may tell the staff member giving you this NOTICE REGARDING RESTRICTED RIGHTS OF INDIVIDUAL or your caseworker if you would like the facility to notify the affected parties.**

**If you need assistance regarding this Notice, ask your caseworker or another staff member for help.**

**Information about the health care services you receive at a mental health or developmental disabilities facility is protected by privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) at 45 CFR 160 and 164. Your personally identifiable health information will only be used and/or released in accordance with HIPPA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110).**