State of Illinois
Department of Human Services

NOTICE REGARDING RESTRICTED RIGHTS OF INDIVIDUALS

Reference: 405ILCS 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 _____ @ _____
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 are given to the individual, mailed to all indicated individuals, and placed in his or her medical record.

Date/Time: _____ Signature Field _____

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).