Queensland Government

Short-Term Approval for the use of Restrictive Practices Application Form

When this form is to be used

This form is to be used by a relevant service provider, for a Short-Term Approval (STA) for the use of physical, mechanical, or chemical restraint and restricting access **only**.

How to complete this form (one per Provider per Client)

This form is designed to be completed electronically. The form can also be printed and completed by hand. P please use black or blue ink.

Please ensure **all sections** (Parts A to E) are completed. Links to information and documents required are included.

The following resource should be consulted when completing this form:
Short-term approval – A guide for service providers

Please send the completed form with all relevant attachments to the departmental delegate in your local region.

Note: Incomplete or unsigned application forms will be returned to the service provider.

Privacy

The information on this form is being collected to enable Seniors and Disability Connect clinical staff to make informed decisions about the use of restrictive practices. The collection is authorised by the *Disability Services Act 2006.* Information may be disclosed to statutory bodies and non-government service providers involved in this process. All personal information will be handled in accordance with the *Information Privacy Act 2009*.

Part A (i) – Adult information

Name of the adult who has impaired capacity for making decisions:	NDIS Participant No:
**Please attach the* QCAT Health professional report *or any other report that makes a declaration regarding the adult's decision-making capacity.*	

Date of Birth: / /	Gender: M ☐ F ☐	Primary Disability:

Does the adult identify as being Aboriginal or Torres Strait Islander?

☐ Yes ☐ No ☐ Not disclosed

☐ Aboriginal
☐ Torres Strait Islander

Are there any other cultural considerations relevant to this application (e.g. does the adult come from a non-English speaking background etc.?). If yes, please outline:

Address:	
Suburb:	Postcode:

Part A (ii) – Service Provider Information

Service Provider:	Is the service provider a registered NDIS provider?	**Yes** ☐	**No** ☐
	Is the adult supported in a Residential Aged Care setting?	**Yes** ☐	**No** ☐
	NDIS Provider Number:		

Contact Person:	Position:	Telephone:
Address:	Suburb:	Postcode:
Email Address:		
**Please briefly outline the support provided (e.g., Accommodation, Community Access etc):*		

Are there other (known) service providers involved in providing support?			**Yes*** ☐ **No** ☐
**Please add an additional page or use the additional information section at the end of the form if there are more than two other service providers.*			
Service Provider:			NDIS No:
Contact Person:	Position:		Telephone:
Address:	Suburb:		Postcode:
Email Address:			
Does this provider wish to be included in the application? *Yes ☐ No ☐			
*If yes, please briefly outline the support provided (e.g., Accommodation, Community Access etc)			

Service Provider:			NDIS No:
Contact Person:	Position:		Telephone:
Address:	Suburb:		Postcode:
Email Address:			
Does this provider wish to be included in the application? *Yes ☐ No ☐			
*If yes, please briefly outline the support provided (e.g., Accommodation, Community Access etc)			

Part B – Background information

Is this the first time you have applied for an STA for this client? **Yes** ☐ **No*** ☐
***Note:** Second or subsequent STAs will only be considered if there are exceptional circumstances.

Have any previous applications been made to QCAT regarding restrictive practice matters?

No ☐ **Yes*** ☐ If Yes, what was the date of this application: / /

*Please provide brief details of this previous application:

Is the adult on any Forensic or Involuntary Treatment Order? **Yes** ☐ **No** ☐

If Yes, please specify:

Is there a QCAT appointed Guardian for a restrictive practice matter (general or respite) for the adult?			
Yes ☐ General ☐ Respite ☐			
Name:			
Address:			
Suburb:	Postcode:		Telephone:
Email Address:			
No ☐ Have steps been taken to have a guardian for a restrictive practice matter (general or respite) appointed by QCAT? **No** ☐ **Yes*** ☐ If yes, what steps have been taken?			
Is there an Informal Decision Maker? Yes ☐ **No** ☐		**Relationship to the adult:**	
Name:			
Address:			
Suburb:	Postcode:		Telephone:
Email Address:			
Is there a Guardian appointed for other matters (e.g., healthcare, day to day)?		**Yes** ☐	**No** ☐
Name:			
Address:			
Suburb:	Postcode:		Telephone:
Email Address:			

Part C – Restrictive Practices Information – What restrictive practice(s) are you requesting approval to use?		
Chemical Restraint (Fixed Dose) ☐	Physical Restraint ☐	Restricting Access ☐
Chemical Restraint (As Required) ☐	Mechanical Restraint ☐	

Description of each restrictive practice for which approval is being sought: **Please attach physical and/or mechanical restraint procedures if requesting approval.*
Please detail the **immediate and serious risk of harm** that, if the approval is not given, the adult's behaviour will cause to the adult or others. **Please attach any relevant behaviour recording sheets and incident reports.*
Outline how this restrictive practice is the **least restrictive** way of ensuring safety of the adult and others:
Outline the alternative strategies attempted to reduce the risk associated with the behaviours:
Outline the positive and negative impacts of the restrictive practice on the adult and others (i.e., co-tenants):

Have any medical specialists and/or other allied health professionals been consulted regarding the adult's behaviour or the use of restrictive practices?			
No ☐ **Yes** ☐ If Yes, please provide details:			
Name:	Profession:	Telephone:	Date consulted:

For chemical restraint the adult's treating doctor must have been consulted. A signed copy of the departmental Clarification of Purpose of Medication form must be provided with this application.	
Treating Doctor:	Date of last consultation: / /
Telephone:	Email:

Please provide a full list of medication the adult is currently taking **(regardless of whether chemical restraint is being applied for).** Please specify N/A if the adult is not taking **any** prescribed medication. **Note:** A Clarification of Purpose of Medication form must be attached if Chemical Restraint is applied for or if a COPM is attached please write;'COPM' in this box.		
Date of last full medication review / /	Medication reviewed by: ☐treating medical professional ☐ pharmacist	
Date of last full medical assessment? (e.g. CHAP) / /		
Date of next full medical assessment (including medication review)? / /		

Please detail the adult's views about the use of the restrictive practice(s). If you have not consulted with the adult, please explain why:
Please provide any additional information relevant to your application:

Part D – Prepared by	
Name:	Position:
Service Provider:	Telephone:
Email Address:	
Signature: _____	Date: / /

Part E – Attachment Checklist	Attached
QCAT Health professional report	☐
Evidence to support the use of restrictive practice, e.g., relevant behaviour recording sheets and incident reports	☐
Physical restraint procedure if requesting approval	☐
Mechanical restraint procedure if requesting approval	☐
Departmental Clarification of Purpose of Medication form if requesting chemical restraint approval	☐
Other e.g., Positive Behaviour Support Plan, medical and allied health reports etc	☐