**Rights Restriction Survey**

This survey is to be used by the support team of a person with IDD when a rights restriction is being used OR being considered for use. Even if a restrictive method is used “for health and safety,” it must be based on the results of a specialized assessment and reviewed by a human rights committee (either FCBDD’s or another provider agency’s).

Name of individual:       DOB:

ISP Span Dates:       to

Form completed by:       Date completed:

Name of individual’s FCBDD service coordinator:       Phone:

Identify restriction in use or proposed (complete a separate survey for each).

Please note location of restriction within ISP if already included in person’s plan.

1. Why is the restriction being used or proposed for use?
2. If a restriction is being used or proposed for use due to a need of this person’s roommate, a detailed description and impact of said restrictive support must be included in this person’s ISP and informed consent obtained.

**IF PROPOSED OR IN USE RESTRICTIVE IS TO MEET THE NEEDS OF THIS PERSON’S ROOMMATE, STOP HERE. BE SURE TO COMPLETE A SEPARATE SURVEY FOR THE ROOMMATE THAT ANSWERS ITEMS 1-11 FOR THAT OTHER PERSON.**

1. If in use, for how long?       days/wks/mos/yrs [ ]  N/A
2. Who is using this particular restriction or who is team proposing will use this restriction? (i.e., parent, paid provider, other. Please indicate name & relationship to individual with IDD.)

1. Under what conditions is this restriction being used or will it be used? (i.e., in response to a particular action or is it/will it always be in place?)
2. What kind of specialized assessment was done to determine the appropriateness of the use of this restriction/proposed restriction?       By whom?       When?       Results?
3. What else has been tried and why was it unsuccessful?
4. What other strategies might be used instead of a rights restriction to support this person at this time?
5. Has the use of this restriction/proposed restriction been determined to be based on the individual’s actions that pose an imminent risk to his/hers/others’ safety? [ ]  YES [ ]  NO

If so, is/will the use of identified/proposed restriction being monitored by a behavioral specialist? [ ]  YES [ ]  NO

If yes, please indicate name, phone #, and e-mail of current behavioral specialist.

If no, please indicate name, phone #, and e-mail of other professional who is/will be monitoring the use of restrictive support.

1. Has the use of this restriction been reviewed by FCBDD/other agency’s human rights committee? [ ]  YES [ ]  NO If so, when was the last review?       If not, who on the team will contact the appropriate HRC to schedule the required review?
2. If the proposed restriction is deemed necessary and is incorporated into this person’s ISP, who will take responsibility for submitting required paperwork to FCBDD Psychology Dept or other agency HRC, presenting the case to HRC, and serving as the ongoing monitor of the use of this restriction?