# Referral for Rights Restriction Review

**Instructions for person providing assistance:**

This referral should be completed with the person supported and their family and support network, as they wish. If they have a Substitute Decision Maker (SDM) with authority to make decisions in the area related to the right that is being restricted, then consent must be obtained from them as well. The process should be clearly explained to the person either way.

Name of person experiencing restriction: _____
Age: _____
Date referral initiated: _____

Support model (check one):
☐ Supported Independent Living ☐ Homeshare / Foster
☐ Shift-staffed home ☐ Employment/Day Service
☐ Other: _____

**This information will be brought to a group of people called the Rights Restriction Review Committee. The review is designed to ensure your rights are respected. The committee helps us ensure that we are doing the right thing.**

Restriction: (Please identify only one restriction per referral)

How are your rights being limited or restricted - please describe the restriction in detail. What do you think about this restriction? What does it keep you from doing?

Background:

Why is this restriction needed? Provide a brief background of why the restriction was developed (include who was involved ie. Person, family, doctor, support network, psychiatrist, mental health services) Attach relevant data if available.

What else has been tried?

Outline all previous attempts at providing less intrusive support (successful or not).

Was consultation with other community or professional resources sought to try to avoid the use of this restriction? (Explain fully)

Have medical or health related impacts been investigated and resolved? (including possible causes from medications)

How long has the restriction been in place? Describe the plan to reduce or eliminate the restriction over time. How long is it anticipated that this restriction will be needed. (Note: referrals without a plan for reduction will be returned without review)

How will this plan be implemented? How will the plan be monitored and documented?

What training have (or will) you, your staff or others responsible for helping with this plan receive?

Have there been any changes in the last 2 years involving your living, work, health, behavior, medications, or major relationships?

Other Information you want to share:

## Review

Staff involved in preparing & submitting the referral:

Signature: _____ Date: _____

Signature: _____ Date: _____

Required additional information (must be included with referral):

- ☐ Completed Risk Assessment Form
- ☐ Completed informed consent form from person (and SDM if applicable)

Supplemental information (check only if included)

- ☐ Supplemental Referral Information form for Psychotropic medications (if applicable)
- ☐ Historical Data to support rationale for restriction (if available)
- ☐ Other (describe: _____)