Mental Health and Wellbeing Act 2022
Sections 126, 127, 128, 129, 131, 132, 133, 134, 135, 136, 137, 138 & 139

MHWA 145

Authority for use of restrictive interventions (including chemical restraint) and observations

Mental Health Statewide UR Number

Local Patient Identifier										
FAMILY NAME										
GIVEN NAMES										
DATE OF BIRTH		SEX		GENDER						

Place patient identification label above

PART F (3): Details of Observations Cont.

Date and Time	Comments / Observations	Completed by:	
		Signature	Designation

Note: If further observation requires recording please use the MHWA145(b) form
To be completed when the person is released from the last restrictive intervention

The person was released from the **last** restrictive intervention on

date _____ at: time 24 hour _____

Given Names: _____ Family Name: _____

Signature: _____ Designation: _____

PART G: Post Restrictive Intervention Communication

Was the patient offered the opportunity to discuss the restrictive intervention?

☐ Yes
☐ No

If Yes, Date: _____

Time: _____

Provided by: _____

If No, why not?

_____

_____

_____

Mental Health and Wellbeing Act 2022
Sections 126, 127, 128, 129, 131, 132, 133, 134, 135, 136, 137, 138 & 139

MHWA 145

Authority for use of restrictive interventions (including chemical restraint) and observations

Mental Health Statewide UR Number

Local Patient Identifier										
FAMILY NAME										
GIVEN NAMES										
DATE OF BIRTH		SEX		GENDER						

Place patient identification label above

MHWA145

Instructions to complete this form

- This form may be completed to document authorisation processes and observations for all restrictive practices engaged under the Mental Health and Wellbeing Act 2022. Specifically:
  - urgent physical restraint
  - physical restraint
  - mechanical restraint
  - seclusion
  - chemical Restraint

Part A of this form:

- A registered nurse can authorise the use of urgent physical restraint if an Authorised Psychiatrist, registered medical practitioner or nurse in charge is not immediately available to authorise the use of urgent physical restraint.
- This section must be completed by the registered nurse who authorises an urgent physical restraint. If further restrictive intervention is required, GO TO PART B

Part B of this form:

- Complete this part for all seclusions, chemical restraints, physical restraints and mechanical restraints.
- With the exception of chemical restraint, all other restraints must be authorised by an Authorised Psychiatrist or Delegate; and if an Authorised Psychiatrist or Delegate is not reasonably available, a Registered Medical Practitioner or the Nurse in Charge.
- Chemical restraint can only be authorised by an Authorised Psychiatrist or Delegate; and if they are not reasonably available, a Registered Medical Practitioner or Nurse Practitioner

Part C of this form:

- This part relates to section 132 (6) and must be filled out by the registered nurse after authorising an urgent physical restraint.

Part D of this form:

- This part relates to section 134 of the Act and must be filled out by the person who authorises the restrictive intervention, if they are not an authorised psychiatrist

Part E of this form:

- This section relates to the obligations under s.134 of the Act. This can be filled out by the authorised psychiatrist or delegate who has been notified of the restrictive intervention. If the authorised psychiatrist or delegate is not reasonably available to examine the person, this requirement can be completed and this section filled out by a registered medical practitioner.
- The Authorised Psychiatrist or Delegate must then examine the person as soon as practicable to decide whether continued use of the restrictive intervention is necessary unless the person has been released in the meantime.
- If the Authorised Psychiatrist or Delegate is not available to examine the person, they must arrange for a Registered Medical Practitioner to examine the person as soon as practicable to decide whether continued use of the restrictive intervention is necessary, unless the person has been released in the meantime.

Part F of this form: Record the type of restrictive intervention and all observations.

The term Authorised Psychiatrist or Delegate means the Authorised Psychiatrist of the service, or Consultant Psychiatrist who has powers delegated under the Mental Health and Wellbeing Act

Patient Information

_____
GIVEN NAMES FAMILY NAME (BLOCK LETTERS)

☐ a Compulsory Patient ☐ a Security Patient ☐ a Forensic Patient

☐ a person receiving treatment in a Designated Mental Health Service on a Voluntary Basis

a patient of: _____
Designated Mental Health Service

Part A: Authorisation for urgent physical restraint

1. I am a Registered Nurse
2. The following urgent physical restraint was used on the person:
   - ☐ upright
   - ☐ side
   - ☐ supine
   - ☐ prone

sales@allanbypress.com.au

APR
2025

Authority to Use Restrictive Intervention

MHWA145

Mental Health and Wellbeing Act 2022
Sections 126, 127, 128, 129, 131, 132, 133, 134, 135, 136, 137, 138 & 139

MHWA 145

Authority for use of restrictive interventions (including chemical restraint) and observations

Mental Health Statewide UR Number

Local Patient Identifier			
FAMILY NAME			
GIVEN NAMES			
DATE OF BIRTH	SEX	GENDER	

Place patient identification label above

3. Urgent physical restraint of the above named person was necessary as a matter of urgency:
   - ☐ to prevent imminent and serious harm to the person.
   - ☐ to prevent imminent and serious harm to another person.
4. All reasonable and less restrictive options have been tried or considered and found to be unsuitable.
5. I have given proper consideration to the decision-making principles for treatment and interventions.
6. Please explain why the urgent physical restraint was necessary, all other less restrictive options tried or considered, and why they were found to be unsuitable.

7. I, _____ notified _____
   (Name of Registered Nurse) (Name of Nurse in Charge, registered medical practitioner or Authorised Psychiatrist or delegate)

   On ☐☐☐☐☐☐☐☐ at: ☐☐☐☐
   date time 24 hour

Signature: _____ Date: ☐☐☐☐☐☐☐☐

IF FURTHER RESTRICTIVE INTERVENTION IS REQUIRED, GO TO PART B.
TO RECORD ALL OBSERVATIONS, GO TO PART H.

Part B: Authorisation for use of restrictive intervention

1. I am:
   - ☐ an Authorised Psychiatrist or Delegate
   - ☐ a Registered Medical Practitioner
   - ☐ a Nurse in Charge (excludes chemical restraint)
   - ☐ a Registered Nurse Practitioner
2. The reason for the use of the restrictive intervention is:
   - ☐ to prevent imminent and serious harm to the person
   - ☐ to prevent imminent and serious harm to another person
   - ☐ to administer treatment to the person (applicable to physical and mechanical restraint only)
   - ☐ to administer medical treatment to the person (applicable to physical and mechanical restraint only)
3. All reasonable and less restrictive options have been tried or considered and found to be unsuitable.
4. I have given proper consideration to the decision-making principles for treatment and interventions set out below.
5. I authorise:
   - ☐ a Physical Restraint
   - ☐ Mechanical Restraint
   - ☐ Seclusion of the Person
   - ☐ Chemical Restraint (excludes Nurse in Charge)
6. **Describe why the restrictive intervention was necessary:**

Mental Health and Wellbeing Act 2022
Sections 126, 127, 128, 129, 131, 132, 133, 134, 135, 136, 137, 138 & 139

MHWA 145

Authority for use of restrictive interventions (including chemical restraint) and observations

Mental Health Statewide UR Number

Local Patient Identifier			
FAMILY NAME			
GIVEN NAMES			
DATE OF BIRTH	SEX	GENDER	

Place patient identification label above

MHWA145

PART F (2): Details of Medical Reviews

Review Number	Name of Authorised Psychiatrist or Registered Medical Practitioner	Date of Review	Time of Review	Type of Restrictive Intervention	Was the Restrictive Intervention continued?	Signature

PART F (3): Details of Observations

Date	Review time	Comments / Observations	Completed by:	
			Signature	Designation

Mental Health and Wellbeing Act 2022
Sections 126, 127, 128, 129, 131, 132, 133, 134, 135, 136, 137, 138 & 139

MHWA 145

Authority for use of restrictive interventions (including chemical restraint) and observations

Mental Health Statewide UR Number

Local Patient Identifier			SEX	GENDER
FAMILY NAME				
GIVEN NAMES				
DATE OF BIRTH				

Place patient identification label above

Part F: Observations during restraint

This form must be completed by a Registered Nurse or Registered Medical Practitioner.

- A Registered Nurse or Registered Medical Practitioner must:
  - Continuously observe a person subject to bodily restraint for the entire period of the restraint.
  - Continuously observe the person subject to chemical restraint for at least one hour after administration of the last dose.
  - Clinically review a person subject to a restrictive intervention as often as is appropriate and at least every 15 minutes.
  - An Authorised Psychiatrist must examine the person as often as is appropriate and at least every 4 hours. If it is not practical for the Authorised Psychiatrist to complete the examination, the Authorised Psychiatrist may direct a Registered Medical Practitioner to do so. **MUST BE RECORDED IN PART F**
  - A person who may authorise the use of a restrictive intervention must immediately take steps to release the person from the restrictive intervention as soon as its use is no longer necessary.

The restrictive intervention(s) being used are (more than one can apply):

☐ Urgent physical restraint (please specify)	☐ Upright	☐ Side	☐ Supine	☐ Prone
☐ Physical restraint (please specify)	☐ Upright	☐ Side	☐ Supine	☐ Prone
☐ Mechanical restraint (please specify)	☐ Wrist	☐ Ankle	☐ Trunk	☐ Whole of body
☐ Seclusion				
☐ Chemical Restraint				

PART F (1) Summary of each Restrictive Intervention Episode undertaken	Date & Time Due	Date & Time Occurred	Type of Restrictive Intervention

Mental Health and Wellbeing Act 2022
Sections 126, 127, 128, 129, 131, 132, 133, 134, 135, 136, 137, 138 & 139

MHWA 145

Authority for use of restrictive interventions (including chemical restraint) and observations

Mental Health Statewide UR Number

Local Patient Identifier			SEX	GENDER
FAMILY NAME				
GIVEN NAMES				
DATE OF BIRTH				

Place patient identification label above

MHWA145

7. **Detail all other less restrictive options tried or considered and explain why they were unsuitable:**

8. **Does the person have an Advance Statement of Preferences?**
   ☐ No ☐ Yes If Yes, was it followed? ☐ Yes ☐ No

9. **Has the persons Next of Kin, Carer, Nominated Support Person, Parent or Guardian been informed of the restrictive intervention?** ☐ Yes ☐ No If No, why not?

If Yes, Date: Time:

Name of Person informed: Informed by:

Location where restraint was commenced

*** The use of chemical restraint for the purposes of transporting a person to or from a place as required by the Act can only be authorised by a Registered Medical Practitioner**

10. Location where restraint was commenced	☐ Aged persons mental health residential service ☐ Community based mental health service ☐ Community Care Unit (CCU) ☐ Emergency Department ☐ Urgent Care Centre (Specify) ..... ☐ Mental health inpatient unit ☐ Prevention and Recovery Care (PARC) ☐ Public hospital - excl. mental health ward (Specify:) ..... ☐ Other: .....
FOR PHYSICAL RESTRAINT, MECHANICAL RESTRAINT OR SECLUSION, GO TO PART D	

11. Chemical Restraint Medication Information	
Dose 1	
The following medication is required (select one option only):	☐ Antipsychotic ☐ Benzodiazepine ☐ Anaesthetic ☐ Agent Other (please specify)
Route of administration:	☐ Oral ☐ Sublingual ☐ Intramuscular ☐ Intravenous ☐ Other (please specify)
Person responsible for prescribing medication:	Given Names:
	Family Name:
	Designation:
Person responsible for administering medication:	Given Names:
	Family Name:
	Designation:
Medication was administered on:	Date:
	Time:

Mental Health Statewide UR Number

Local Patient Identifier		
FAMILY NAME		
GIVEN NAMES		
DATE OF BIRTH	SEX	GENDER

Place patient identification label above

Dose 2 (if required within 60 minutes of commencing Dose 1)	
The following medication is required (select one option only):	☐ Antipsychotic ☐ Benzodiazepine ☐ Anaesthetic ☐ Agent Other (please specify)
Route of administration:	☐ Oral ☐ Sublingual ☐ Intramuscular ☐ Intravenous ☐ Other (please specify)
Person responsible for prescribing medication:	Given Names:
	Family Name:
	Designation:
Person responsible for administering medication:	Given Names:
	Family Name:
	Designation:
Medication was administered on:	Date:
	Time:
Dose 3 (if required within 60 minutes of commencing Dose 1)	
The following medication is required (select one option only):	☐ Antipsychotic ☐ Benzodiazepine ☐ Anaesthetic ☐ Agent Other (please specify)
Route of administration:	☐ Oral ☐ Sublingual ☐ Intramuscular ☐ Intravenous ☐ Other (please specify)
Person responsible for prescribing medication:	Given Names:
	Family Name:
	Designation:
Person responsible for administering medication:	Given Names:
	Family Name:
	Designation:
Medication was administered on:	Date:
	Time:

Part C: Notification Requirement for Urgent Physical Restrictive Interventions

To be completed by the registered nurse after authorising an urgent physical restraint under the Act as the Nurse in Charge, Nurse Practitioner or Registered Medical Practitioner or authorised psychiatrist or delegate were not reasonably available.

I, _____ notified _____
(Name of Registered Nurse) (Name of Nurse in Charge, registered medical practitioner or Authorised Psychiatrist or delegate)

On ☐☐☐☐☐☐☐☐ at: ☐☐☐☐
date time 24 hour

Signature: _____ Date: ☐☐☐☐☐☐☐☐

Mental Health and Wellbeing Act 2022
Sections 126, 127, 128, 129, 131, 132, 133, 134, 135, 136, 137, 138 & 139
MHWA 145
Authority for use of restrictive interventions (including chemical restraint) and observations

MHWA145

Mental Health Statewide UR Number

Local Patient Identifier		
FAMILY NAME		
GIVEN NAMES		
DATE OF BIRTH	SEX	GENDER

Place patient identification label above

Part D: Notification Requirement for all other Restrictive Interventions

To be completed by the practitioner who authorises all other restrictive intervention under the Act when the authorised Psychiatrist or delegate is NOT the authorising practitioner

I, _____ notified _____
(Name of Authorised Practitioner) (Name of Authorised Psychiatrist or delegate)

On ☐☐☐☐☐☐☐☐ at: ☐☐☐☐ of the authorising of restrictive intervention
date time 24 hour

Signature: _____ Date: ☐☐☐☐☐☐☐☐

GO TO PART E

Part E: Authorisation for continued use of restrictive intervention

To be filled out by the authorised psychiatrist or delegate who has been notified of the restrictive intervention to address requirements of s.134 of the Act If the authorised psychiatrist or delegate is not reasonably available to examine the person, this requirement can be completed and this section filled out by a registered medical practitioner.

I am: ☐ an Authorised Psychiatrist or Delegate ☐ a Registered Medical Practitioner

☐ I have examined the person and have given proper consideration to the decision making principles for treatment and interventions

AND

☐ I am not satisfied continued use of restraint is necessary and direct no further restraint is used and the person must be released immediately

OR

☐ I am satisfied the continued use of the current restraint is necessary, that all less restrictive options have been tried or considered and found to be unsuitable. I provide the following instructions regarding continued use as below:

1. The person MUST be medically examined by an Authorised Psychiatrist or delegate or a Registered Medical Practitioner every _____ hours (at least every 4 hours) and recorded in **PART F (1)**
2. Observations of the person MUST be undertaken and recorded at least every 15 minutes and recorded in **PART F (3)**

Signature: _____ ☐☐☐☐☐☐☐☐ at: ☐☐☐☐
Signature of Authorised Psychiatrist or Delegate / Registered Practitioner date time 24 hour

Given Names: _____ Family Name: _____

GO TO **PART F**