NYS Office for People With Developmental Disabilities

Intervention Outcome Form MIPS and/or Sedation

This form or its equivalent should be completed immediately after a dental or medical appointment at which Medical Immobilization/Protective Stabilization and/or Sedation is used. Dental or medical staff, agency staff or the family care provider may complete this form. One copy of this form must be kept in the person receiving services' record at the agency and one copy should be given to the dental or medical provider for their file.

Name of Individual Receiving Services	Date of Birth

What was the type of treatment provided at this appointment (i.e. cleaning, x-ray)?

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Type of MIPS and/or Sedation Used (if any) – Check All That Apply

- ☐ Manual Hold ☐ Arms ☐ Legs ☐ Head
- ☐ Mechanical Device ☐ Arms ☐ Legs ☐ Head ☐ Torso/Trunk
- ☐ Papoose Board
- ☐ Sedation

If MIPS was used, who performed the technique?

- ☐ Office Staff
- ☐ Health Care Provider
- ☐ Other ______________________________
- ☐ Agency Staff
- ☐ Family/Advocate

If MIPS was used, how long was it used (approximately)?

Describe the effectiveness of the MIPS and/or Sedation:

- ☐ Person cooperated and procedure completed.
- ☐ Person did not fully cooperate but procedure completed.
- ☐ Person did not cooperate and procedure only partially completed.
- ☐ Person did not cooperate and procedure not completed.

List any post appointment instructions or monitoring required.

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Was MIPS and/or sedation used on an emergency basis? ☐ No ☐ Yes

Name of Individual Completing this Form ____

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Title ____________________________________ Date ______/______/______

Signature ____________________________________