

# NIMRS Deletion Request Form

## Instructions for Completing the NIMRS Deletion Request Form

In order to facilitate requests for deletions of incidents or restraints/seclusion episodes in NIMRS (New York State Incident Management & Reporting System), please use the NIMRS Deletion Request Form. All requests require sign-off by the CEO/Executive Director and the Director of Quality Assurance. For local providers who may not have a Director of Quality Assurance, the person serving in that function should sign the request.

Please note that the form has three tables that can be used. The first is for the deletion of incidents. The second is for the deletion of an entire episode of restraint/seclusion, i.e., all of the interventions/orders in an episode. The third table is for the deletion of one or more specific interventions or orders within an episode. Each Request Form must contain the following information:

- Facility/Agency Name (Please enter on each page you submit.) • Facility/Agency Code (Please enter on each page you submit.)
- Complete information requested for the table(s) being used.
- Signatures of the CEO/Executive Director and the QA Director, along with the date signed.
- Please mail or fax the signed, completed forms to:

**Mail: Office of Quality Improvement - 6th Floor**

**Office of Mental Health**

**44 Holland Avenue**

**Albany, N.Y. 12229**

**Fax: (518) 402-4401 or (518) 474-7065**

Thank you for your cooperation in this matter.

If you have any questions, please call Tel: (518) 474-3619.



**Office of  
Mental Health**

# NIMRS Deletion Request Form

FACILITY NAME \_\_\_\_\_

FACILITY CODE \_\_\_\_\_

Please sort table by Incident Number

<b>REQUEST TO DELETE AN INCIDENT</b>					
Incident No.	Incident Date	Case No.	Clients Full Name (As it appears in the Incident)	DOB	Reason for Deletion (If duplicate, give # of correct entry)

Please sort table by Episode Number

<b>REQUEST TO DELETE A RESTRAINT/SECLUSION EPISODE</b>					
Episode No.	Episode Date	Case No.	Clients Full Name (As it appears in the Episode)	DOB	Reason For Deletion (If duplicate, give # of correct entry)



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# NIMRS Deletion Request Form

FACILITY NAME \_\_\_\_\_

FACILITY CODE \_\_\_\_\_

Please sort table by Episode Number and Order Number

<b>REQUEST TO DELETE A RESTRAINT/SECLUSION ORDER/INTERVENTION</b>						
Episode No.	Order / Intervention #	Date	Case No.	Client=s Full Name (As it appears in the Episode)	DOB	Reason For Deletion (If duplicate, give # of correct entry)

Signature CEO \_\_\_\_\_ Date \_\_\_\_\_ Signature OQI \_\_\_\_\_ Date \_\_\_\_\_

Signature QA Director \_\_\_\_\_ Date \_\_\_\_\_



**Office of  
Mental Health**