PHYSICAL RESTRAINT ORDER FORM

PHYSICAL RESTRAINTS MUST BE RE-ORDERED MONDAY AND THURSDAY

PHYSICAL RESTRAINTS NOT RENEWED WILL BE DISCONTINUED

1. TYPE OF RESTRAINT:

___ POSEY VEST
___ ONE LEG RESTRAINT
___ TWO LEG RESTRAINTS
___ OTHER (PLEASE SPECIFY) _____

___ ONE ARM RESTRAINT (NON-LEATHER)
___ TWO ARM RESTRAINTS (NON-LEATHER)
___ FOUR EXTREMITY RESTRAINTS

_____

2. TIME FRAMES: Must be checked every 30 minutes while restrained. All restraints must be released every 2 hours and body parts examined for signs of stress and/or injury.

___ WHEN OUT OF BED IN A CHAIR
___ AT ALL TIMES
___ OTHER (PLEASE SPECIFY) _____

_____

3. CLINICAL RATIONALE: (Check at least one, and/or as many as appropriate)

___ AGITATION
___ TO PREVENT FALLS
___ TO PREVENT STAFF INJURY
___ CONFUSION
___ TO PREVENT HARM TO SELF
___ ALCOHOLIC DELIRIUM TREMORS
___ TO PREVENT REMOVAL OF MEDICAL THERAPEUTIC DEVICES
___ OTHER (PLEASE SPECIFY) _____

_____

Physician's Signature: _____

Date/Time: _____