PATIENT STICKER

**Seclusion and Restraint Order**

**(Must be on canary yellow paper and two-sided)**

LCC NNAMHS SNAMHS PRIVATE (specify)

**ALL INFORMATION MUST BE PRINTED CLEARLY AND ACCURATELY**

**Gender:** Male Female **Denial of rights completed and filed:** RN Initial \_\_\_\_\_\_\_\_

**Family Notified:**  Yes No No consent to notify family/significant other

Patient refuses family/significant other notification

**Rational for Seclusion and/or Restraint:**  Harmful to self Harmful to others

**Methods used to avoid Seclusion and/or Restraint:**  Verbal reassurance/redirection

Vent feelings Time out Limit setting

1-1 Interaction with staff Stimulus reduction Environmental change

**Medication(s):**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Dosage: | Time: | PO IM |
| Name: | Dosage: | Time: | PO IM |
| Name: | Dosage: | Time: | PO IM |
| Name: | Dosage: | Time: | PO IM |

**Is the patient medically compromised:**  No Yes **If yes, check all that apply:**

Morbid obesity Spinal injury Recent vomiting Pregnancy

Seizure precautions Known history of cardiac/respiratory disease Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Clinical Assessment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**RN Assessment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Appropriate observation of patient noted and charted:**  Yes No RN Initial \_\_\_\_\_\_\_\_

**Behavioral criteria necessary for release:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Physician Order**

**Patient placed in:**  Seclusion Locked seclusion Cuff / belt Legs Wrists

4-point 5-point Mitts Geri chair Physical intervention required

**Adult (18+ years):** Restraint (up to 4 hours) Seclusion (up to 4 hours) Seclusion/Restraint (up to 4 hours)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Start:** | Date: | Time: | Day: | Shift: | Unit: | Length:  \_\_\_\_\_\_\_\_\_\_\_\_ |
| **End** | Date: | Time: | Day: | Shift: | Unit: |

**Continuation of Order**

**RN may extend order once, not to exceed four (4) additional hours:** Yes No

The RN evaluation and documentation for continuation of order must include a face-to-face reassessment of the patient’s current behavior that warrants the extension of the seclusion/restraint. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Discussed with Physician:**  Yes No **RN Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_

**Verbal /Phone order by Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_

**RN Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_

**Physician Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_

**Order noted by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_

PATIENT STICKER

**Seclusion / Restraint Review**

**(Must be on canary yellow paper and two-sided)**

**DON (print name)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Reviewed Order/Actions Approved:** Yes No

**Notes:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DON Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_

**Medical Director (print name)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Reviewed Order/Actions Approved:** Yes No

**Notes:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical Director Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_

**Agency Director (print name)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Reviewed Order/Actions Approved:** Yes No

**Notes:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Agency Director Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_

**Division MHDS (print name)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Reviewed Order/Actions Approved:** Yes No

**Notes:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Division MHDS Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_