

Seclusion and Restraint Form

PATIENT/CONSUMER NUMBER: _____

PATIENT/CONSUMER AGE: _____

Rationale for seclusion and/or restraint:

Harmful to self Harmful to others

Methods used to avoid restraint and/seclusion:

Ventilation of feelings Verbal reassurance/redirection 1:1 interaction with staff Reduction in stimuli

Environmental change Limit setting Time away from others

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

Morbid obesity Spinal injury Known history of cardiac or respiratory disease

Recent vomiting Pregnancy On seizure precautions Other: _____

RN assessment: _____

Physician's clinical assessment justifying use of seclusion or restraint (Provide detailed narrative of incident and plan to prevent further denial of rights):

Physician's behavioral criteria necessary for release: _____

Patient Outcomes (Did patient improve following restraint? Did injury occur?): _____

Adults: Seclude for up to 4 hours Restrain for up to 4 hours

Children 9 – 17 Years of Age: Seclude for up to 2 hours Restrain for up to 2 hours

Children < 9 Years of Age: Seclude for up to 1 hour Restrain for up to 1 hour

Patient placed in:

SECLUSION: Date: _____ Start Time: _____ (AM/PM) End Time: _____ (AM/PM)

PHYSICAL RESTRAINT: Date: _____ Start Time: _____ (AM/PM) End Time: _____ (AM/PM)

CHEMICAL RESTRAINT: Date: _____ Time: _____ (AM/PM)

Medication Administered: _____ Dose: _____ P.O. I.M.

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MECHANICAL RESTRAINT: Date: _____ Start Time: _____ (AM/PM) End Time: _____ (AM/PM)

cuff/belt legs wrist 4-point 5-point mitts restraint chair spit hood

Patient's family or legal guardian notified of the seclusion or restraint event?: Yes No

Physician Name: _____ Date: _____

Physician Signature: _____ Date: _____

Registered Nurse Name: _____ Date: _____