

RESTRAINT OR SECLUSION PRESCRIPTION

Restraint or Seclusion is prescribed for no more than _____ minutes.

Type of Prescription

Restraint
 Seclusion

Restraint Type:

Four Point
 Five Point
 Ambulatory

Location:

Program/Ward: _____
 Room: _____
 Other: _____

Where Restrained: Bed Chair Transport Board

Reason for Use: Prevention of Self-harm Prevention of Harm to Others

Restraint/Seclusion Beginning: Date: _____ Time: _____ **Ending:** Date: _____ Time: _____

Person assessing the need for emergency restraint/seclusion: _____

Order From: (Dr/PAC): _____ **To:** _____ **Read back (if a verbal order):**

Specific reason for prescription: _____

Interventions attempted to de-escalate the emergency and results: (Include time & staff names)

Specific Instructions based on the patient's medical or psychiatric condition, history of abuse or restraint and seclusion history: _____

Specific measurable release criteria: _____

RN Signature: _____ **Date:** _____ **Time:** _____

Physician/Physician Assistant face-to-face assessment: _____ **Date:** _____ **Time:** _____

Signature: _____

