

HealthCare **PHYSICIAN ORDER SHEET**  
**RESTRAINT**

START DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ END DATE \_\_\_\_\_ TIME: \_\_\_\_\_

**STANDARD FOR THE USE OF ACUTE MED/SURG RESTRAINT(S)**  
Both cognitive and behavioral impairments must be present. Using both columns check all that apply.

<p><b>COGNITION</b></p> <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input type="checkbox"/> Unable to follow instructions <input type="checkbox"/> Lack of awareness of potential harm to self <input type="checkbox"/> Hallucinating <input type="checkbox"/> Delusional <input type="checkbox"/> Delirious <input type="checkbox"/> Other _____	<p><b>BEHAVIOR</b></p> <input type="checkbox"/> Persistently trying to disconnect/dislodge medical equipment. <input type="checkbox"/> Moving/thrashing in a manner that interferes with care <input type="checkbox"/> Disrupting a surgical / wound site in a manner that could compromise healing. <input type="checkbox"/> Attempting to ambulate in a weakened condition <input type="checkbox"/> Other _____
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**ORDER MAY NOT EXCEED 24 HOURS**

**STANDARD FOR THE USE OF BEHAVIORAL RESTRAINT(S)**

Unanticipated outburst of aggressive/violent behavior posing imminent threat of physical injury to self or others  
Refer to progress note for specific assessment of behavior

**ORDER MAY NOT EXCEED 4 HRS FOR AN ADULT 18 AND OLDER, 2 HRS FOR CHILDREN BETWEEN THE AGES OF 8 - 17  
1 HR FOR CHILDREN UNDER 8.**

**A face-to-face assessment by a physician must be completed and documented within one hour of applying the restraint.**

**ALTERNATIVES TO RESTRAINTS: A - ATTEMPTED C - CONSIDERED: Circle all that apply**

A	C	Verbal instruction / reorientation
A	C	Pain assessment / intervention
A	C	Toileting needs assessed / addressed
A	C	Medical device covered with material - e.g. IV site wrapped with gauze
A	C	Equipment moved out of patient's view
A	C	Family member requested to supervise patient
A	C	Monitoring provided by professional sitter
A	C	Companionship provided by visitors
A	C	Placed patient closer to the nursing station
A	C	Provided relaxation intervention e.g. back rub, soft music
A	C	Modified environment: limited number of caregivers, adjusted lighting, decreased noise as much as possible
A	C	Boundary cues: tape markers, STOP sign
A	C	Diversional activities: stacking papers, magazines, newspapers, puzzles, snacks, coloring books
A	C	Other: _____

**TYPE OF RESTRAINT:**

<input type="checkbox"/> Soft limb;	<input type="checkbox"/> Bilateral Upper Extremities	<input type="checkbox"/> Bilateral Lower Extremities	<input type="checkbox"/> RU Extremity
	<input type="checkbox"/> LU Extremity	<input type="checkbox"/> RL Extremity	<input type="checkbox"/> LL Extremity
	<input type="checkbox"/> Soft Belt	<input type="checkbox"/> Full Body	<input type="checkbox"/> Mittens
	<input type="checkbox"/> Other physical device: _____		
	<input type="checkbox"/> Full side rails	<input type="checkbox"/> Geri-chair	
	<input type="checkbox"/> Other equipment/mechanical device: _____		
	<input type="checkbox"/> Medication - REFER TO STANDARD PHYSICIAN ORDER SHEET		

**CRITERIA FOR TRIAL RELEASE: Check all that apply**

Able to follow instructions  
 Awake, alert, oriented  
 Calm, quiet  
 Medical devices e.g. catheters / drains / dressings removed  
 Other: \_\_\_\_\_

Time restraint(s) initiated: \_\_\_\_\_

Patient informed of need for restraints:  Yes  No If no, comment \_\_\_\_\_

Family informed of need for restraints:  Yes  No If no, comment \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Time of Written Order: \_\_\_\_\_

Unit Secretary	Sig/Time: _____
Nurse	Sig/Time: _____

Verbal order  Telephone order