

**Behavioral Health
SECLUSION/RESTRAINT PHYSICIAN ORDER FORM
(continued)**

Instructions: This form must be filled out completely and signed by the Physician

- YES** There is imminent risk that the patient will harm himself/herself, staff
 NO or others if physical intervention is not implemented.

DESCRIBE PATIENT'S BEHAVIOR (S): _____

Interventions that have been attempted:

Re-direction _____ Medication _____ Time out _____ One to One _____ Other: _____

- YES** INFORMED OF RISK FACTORS-PROCEED WITH INTERVENTION
 NO

SECLUSION X _____ HOURS

RESTRAINT: 2 PT. ___ 4 PT. ___ X _____ HOURS

PATIENT PLACED IN SECLUSION/RESTRAINT: DATE _____ TIME: _____ AM _____ PM _____

BEHAVIORAL CRITERIA FOR DISCONTINUING RESTRAINT/SECLUSION: _____

MEDICATION REVIEW: NO CHANGES INDICATED _____ CHANGES LISTED BELOW _____

M.D. SIGNATURE _____ Date: _____ Time: _____ AM _____ PM _____

RN Signature: _____

Psychiatrist Signature: _____

Risk Factors:

CARDIAC PROBLEMS:

H/O Myocardial Infarction
Congestive Heart Failure
Arrhythmias

RESPIRATORY PROBLEMS:

COPD
Asthma
Other:

OTHER PROBLEMS:

H/O Seizures
H/O Fractures
Diabetes.

Psychosocial History:

History of Sexual Abuse/Trauma/Rape
History of psychological harm related
To seclusion or restraint

