

Behavioral Restraint Physician Orders – Single Episode

- Initial evaluation / order must be performed within one hour of initiation of restraints.
- Re-evaluation / order is performed every:
 - 4 hours - patients 18 years or older
 - 2 hours - patients 9 to 17 years
 - 1 hour - patients 8 years and younger

The evaluation may be performed by a Specialty Trained RN, Physician / LIP. If evaluation is performed by a Specialty Trained RN, a telephone order must be obtained from the physician / LIP. A physician / LIP must perform an in-person evaluation at least every:

- 8 hours - patients 18 years or older
- 4 hours - patients 17 years and younger

IN-PERSON EVALUATION

Current Condition		
Current Behavior	<input type="checkbox"/> Demonstrates control over behavior <input type="checkbox"/> Follows directions <input type="checkbox"/> Cooperative <input type="checkbox"/> Verbalizes coping skills <input type="checkbox"/> Other	<input type="checkbox"/> Unable to control behavior <input type="checkbox"/> Combative/assaultive <input type="checkbox"/> Resistant <input type="checkbox"/> Defiant <input type="checkbox"/> Demanding <input type="checkbox"/> Crying <input type="checkbox"/> Yelling <input type="checkbox"/> Self harm behavior <input type="checkbox"/> Other
Pre-existing medical condition	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No
Physical disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No
History of sexual abuse	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No
History of physical abuse	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No
Current medications contributing to current behavior	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No
Abnormal laboratory	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Order:

Initial evaluation / order Re-evaluation / Order

Behavioral Restraints: Continue Discontinue

▪ Type of Restraints:

Upper extremities – Left Right Bilateral

Lower extremities – Left Right Bilateral

Torso

In-person evaluation performed by: MD / LIP, or Specially Trained RN: (signature) _____

MD / LIP Signature: _____ ID# : _____

Telephone Order: _____

Date: _____ Time: _____

