

Clinical Record Number

Surname _____ First Name _____ D.O.B _____

Bed Number _____ Doctor _____

ST GEORGE DIVISION OF GENERAL PRACTICE

RESTRAINT AUTHORISATION

MEDICAL PRACTITIONER'S ASSESSMENT & PLAN	MEDICAL PRACTITIONER'S 12 WEEKLY EVALUATION				
REASON FOR RESTRAINT:	STRATEGY EFFECTIVE ↓ CONTINUE <input type="checkbox"/>	STRATEGY EFFECTIVE ↓ CONTINUE <input type="checkbox"/>	STRATEGY EFFECTIVE ↓ CONTINUE <input type="checkbox"/>	STRATEGY EFFECTIVE ↓ CONTINUE <input type="checkbox"/>	STRATEGY EFFECTIVE ↓ CONTINUE <input type="checkbox"/>
TYPE OF RESTRAINT USED DETAILS BELOW	<input type="checkbox"/> OR STRATEGY INEFFECTIVE ↓ DISCONTINUE <input type="checkbox"/>	<input type="checkbox"/> OR STRATEGY INEFFECTIVE ↓ DISCONTINUE <input type="checkbox"/>	<input type="checkbox"/> OR STRATEGY INEFFECTIVE ↓ DISCONTINUE <input type="checkbox"/>	<input type="checkbox"/> OR STRATEGY INEFFECTIVE ↓ DISCONTINUE <input type="checkbox"/>	<input type="checkbox"/> OR STRATEGY INEFFECTIVE ↓ DISCONTINUE <input type="checkbox"/>
TIME(S) RESTRAINT TO BE APPLIED:	<input type="checkbox"/> SEE CHANGES MADE TO PLAN <input type="checkbox"/>	<input type="checkbox"/> SEE CHANGES MADE TO PLAN <input type="checkbox"/>	<input type="checkbox"/> SEE CHANGES MADE TO PLAN <input type="checkbox"/>	<input type="checkbox"/> SEE CHANGES MADE TO PLAN <input type="checkbox"/>	<input type="checkbox"/> SEE CHANGES MADE TO PLAN <input type="checkbox"/>
SPECIAL CONDITIONS:	<input type="checkbox"/> DR SIGNATURE DATE / /	<input type="checkbox"/> DR SIGNATURE DATE / /	<input type="checkbox"/> DR SIGNATURE DATE / /	<input type="checkbox"/> DR SIGNATURE DATE / /	<input type="checkbox"/> DR SIGNATURE DATE / /
DR SIGNATURE DATE					

COMPLETED BY PERSON RESPONSIBLE

I understand and agree the interventions above are necessary as a last resort and will be reviewed regularly for other alternatives

Signed by person responsible: Name of person: Date