

Clinical Record Number _____

Surname _____ First Name _____ D.O.B _____

Bed Number _____ Doctor _____

ST GEORGE DIVISION OF GENERAL PRACTICE

SAFETY AUTHORISATION

MEDICAL PRACTITIONER'S ASSESSMENT & PLAN	MEDICAL PRACTITIONER'S 12 MONTHLY EVALUATION				
REASON FOR SAFETY DEVISE:	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 SAFETY DEVISE USED <input type="checkbox"/> LAP BELT <input type="checkbox"/> FIXED TABLETOPS <input type="checkbox"/> BED RAILS <input type="checkbox"/> OTHER (SPECIFY) _____	OR STRATEGY INEFFECTIVE ↓ DISCONTINUE <input type="checkbox"/>	OR STRATEGY INEFFECTIVE ↓ DISCONTINUE <input type="checkbox"/>	OR STRATEGY INEFFECTIVE ↓ DISCONTINUE <input type="checkbox"/>	OR STRATEGY INEFFECTIVE ↓ DISCONTINUE <input type="checkbox"/>	OR STRATEGY INEFFECTIVE ↓ DISCONTINUE <input type="checkbox"/>
TIME(S) SAFETY DEVISE TO BE APPLIED:	SEE CHANGES MADE TO PLAN <input type="checkbox"/>	SEE CHANGES MADE TO PLAN <input type="checkbox"/>	SEE CHANGES MADE TO PLAN <input type="checkbox"/>	SEE CHANGES MADE TO PLAN <input type="checkbox"/>	SEE CHANGES MADE TO PLAN <input type="checkbox"/>
SPECIAL CONDITIONS: DR SIGNATURE _____ DATE _____	DR SIGNATURE _____ DATE / /	DR SIGNATURE _____ DATE / /	DR SIGNATURE _____ DATE / /	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