

St George Division of General Practice: Restraint Authorisation form

Clinical Record Number _____		
Surname _____	First Name _____	D.O.B _____
Bed Number _____	Doctor _____	

**VALID FOR 12
WEEKS ONLY**

Risk safety Assessment must be attended prior to restraint authorisation and care plan updated at each review

ASSESSMENT FOR NEED OF RESTRAINT (INCLUDING PREVIOUS MEASURES TAKEN)

CIRCUMSTANCES WHEN RESTRAINT MAY BE USED:

TYPE OF RESTRAINT

MEDICAL PRACTITIONERS SIGNATURE: _____ DATE: / /

CONSENT RESIDENT /PERSON RESPONSIBLE

The need for physical/chemical restraint of _____ has been explained to me and I understand the necessity for this action.

Dated: _____ Signed: _____ Relationship to Resident _____

DATE REVIEW DUE

RESTRAINT REVIEW

Additional comments.....

Medical Practitioners Signature _____ Date: _____

Resident/Person responsible signature _____ Date: _____

DATE REVIEW DUE

RESTRAINT REVIEW

Additional comments.....

Medical Practitioners Signature _____ Date: _____

Resident/Person responsible signature _____ Date: _____

DATE REVIEW DUE

RESTRAINT REVIEW

Additional comments.....
.....

Medical Practitioners Signature _____ Date: _____

Resident/Person responsible signature _____ Date: _____

DATE REVIEW DUE

RESTRAINT REVIEW

Additional comments.....
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