<p>| | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Type and Time of Restraints applied:</td>
<td>_____ point; _____ AM PM</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Time Patient Assessment completed:</td>
<td>_____ AM PM</td>
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<tr>
<td>3.</td>
<td>Emotional Trauma/Distress (If Yes, explain):</td>
<td>☐ Yes ☐ No</td>
<td></td>
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<tr>
<td>4.</td>
<td>Patient Comfortable (If No, explain):</td>
<td>☐ Yes ☐ No</td>
<td></td>
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<tr>
<td>5.</td>
<td>Skin Integrity Intact (If No, explain):</td>
<td>☐ Yes ☐ No</td>
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<td>6.</td>
<td>Injury (If Yes, explain):</td>
<td>☐ Yes ☐ No</td>
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<td>7.</td>
<td>Respiratory Impairment (If Yes, explain):</td>
<td>☐ Yes ☐ No</td>
<td></td>
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<td>8.</td>
<td>Circulatory Impairment (If Yes, explain):</td>
<td>☐ Yes ☐ No</td>
<td></td>
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<tr>
<td>9.</td>
<td>Neuromuscular Impairment (If Yes, explain):</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Vital Signs Within Normal Limits (If No, explain):</td>
<td>☐ Yes ☐ No</td>
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<tr>
<td></td>
<td>BP</td>
<td>P</td>
<td>R</td>
</tr>
<tr>
<td>11.</td>
<td>Dr. _____________ notified at ____________ AM PM. Date: _____</td>
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<td>Print __________________ (MD/ RN/PA) Sign __________________ Date _____</td>
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See Over for Plan of Care/Focus Note (front)