SUNY DOWNSTATE Medical Center
University Hospital of Brooklyn

Name	
MR#:	N/S:
DOB:	Service/Doctor:

FACE-TO-FACE ASSESSMENT WITHIN ONE HOUR OF APPLICATION OF RESTRAINTS/SECLUSION

1. **Type and Time of Restraints applied: _____ point; _____ AM PM**

2. **Time Patient Assessment completed: _____ AM PM**

3. **Emotional Trauma/Distress (If Yes, explain): ☐ Yes ☐ No**

_____

_____

4. **Patient Comfortable (If No, explain): ☐ Yes ☐ No**

_____

_____

5. **Skin Integrity Intact (If No, explain): ☐ Yes ☐ No**

_____

_____

6. **Injury (If Yes, explain): ☐ Yes ☐ No**

_____

_____

7. **Respiratory Impairment (If Yes, explain): ☐ Yes ☐ No**

_____

_____

8. **Circulatory Impairment (If Yes, explain): ☐ Yes ☐ No**

_____

_____

9. **Neuromuscular Impairment (If Yes, explain): ☐ Yes ☐ No**

_____

_____

10. **Vital Signs Within Normal Limits (If No, explain): ☐ Yes ☐ No**

BP _____ P _____ R _____ T _____

11. **Dr. _____ notified at _____ AM PM. Date: _____**

Print _____ (MD/ RN/PA) Sign _____ Date _____

See Over for Plan of Care/Focus Note (front)

Name	
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DOB:	Service/Doctor:

FACE-TO-FACE ASSESSMENT WITHIN ONE HOUR OF APPLICATION OF RESTRAINTS/SECLUSION FOCUS NOTE

FOCUS:

DATA:

ACTION:

RESPONSE:

(back)