



PATIENT I.D. DATA:
(name, DOC #, birthdate)

RESTRAINED PATIENT ASSESSMENT

To be completed upon application of restraints; at least every 15 minutes for the first hour; then every two hours or after every opportunity to stand/walk; and upon removal.

Facility/Unit:

DATE <small>(month/day/year)</small>	TIME <small>(24-hour clock)</small>	Describe level of consciousness, circulation, ability to move extremities, any injuries, any immediate medical/mental health concerns, and actions taken as a result of the assessment.	INITIAL AND STAMP

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.