



# Restraint Checklist



Patient's Name: \_\_\_\_\_

PCR Number: \_\_\_\_\_ Date: \_\_\_\_\_

**It is recommended that a Restraint Checklist be completed with any restraint use.**

**1. Reason for restraint (check all that apply):**

- Patient attempting to hurt self
- Patient attempting to hurt others
- Patient attempting to remove medically necessary devices

**2. Attempted verbal reassurance / redirection?**

- Yes
- No

**3. Attempted environmental modification? (i.e. remove patient from stressful environment)**

- Yes
- No

**4. Received medical control order for restraints?**

- Yes \_\_\_\_\_, MD
- No (Medical Control Physician Name Here)

**5. Time and Type of restraint applied (check all that apply):**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_AM/PM

**Limb restraints:**

- LUE
- RUE
- LLE
- RLE

**Chemical Restraint:**

- Yes
- No

If Yes: Drug Used: \_\_\_\_\_

Total Dose: \_\_\_\_\_

**6. Vital signs and extremity neurovascular exam should be taken every 10 minutes.**

**7. Transport Position (Patient should NOT be in prone position)**

- Supine position for transport
- Lateral recumbent position for transport

Signature: \_\_\_\_\_

**(EMS Lead Crew Member)**