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 ________________________________, MD

5. Time and Type of restraint applied (check all that apply):
   - Date: _____/_____/_____ Time: ______AM/PM
   - ☐ LUE
   - ☐ RUE
   - ☐ LLE
   - ☐ RLE
     If Yes: Drug Used: _______________________________
     Total Dose: ________

6. Vital signs and extremity neurovascular exam should be taken every 15 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)