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 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)