CVH-618 **CONNECTICUT VALLEY HOSPITAL**

New 5/18 **Request for Use of Non Standard Mechanical Restraint**

Patient Name: _____

[ ] General Psychiatry Division

[ ] Addiction Services Division

MPI #: _____ *Print or Addressograph Imprint*

Approval of use of a Non-Standard Mechanical Restraint is being requested from the:

- Chief of Professional Services through the Division Service Medical Director
- Nurse Executive through the Chief of Patient Care Services

Date of Request: _____ Time: _____ AM/PM Unit: _____ **Fax #:** 262-_____

Type of Mechanical Restraint Requested:

[ ] Posey Net

[ ] Other: _____

Clinical Indication for Non Standard Restraint: _____

_____

_____

_____

_____

Use of Non-Standard Mechanical Restraint Requested by:

Attending Psychiatrist: _____ _____ _____

Signature Print Name Date

Fax Completed Form to:

Chief of Professional Services	262-5989	Date: _____	Time: _____	AM/PM
Nursing Executive	262-5895	Date: _____	Time: _____	AM/PM

Request for Use of Non-Standard Medical Device for the above listed patient is (*check one*):

[ ] Denied [ ] Approved: Authorized for _____ days

by: _____ _____ _____

Signature Chief of Professional Services Print Name Date

and

by: _____ _____ _____

Signature Nurse Executive Print Name Date

Deliver original to unit listed above.

File the signed original form in the Physician Order section of the medical record following the corresponding Physician Order for Seclusion/Restraint/Special Observation Form CVH-8e