CVH-480c **CONNECTICUT VALLEY HOSPITAL** Patient Name: _____
Rev. 1/10 **PART III – Reassessment by RN and MD**
Reorder of Seclusion/Restraint by MD MPI # _____ *Print or Addressograph Imprint*

Division: [ ] General Psychiatry [ ] Whiting Forensic [ ] Addiction Services Unit: _____

REORDER: Procedure is: [ ] Seclusion [ ] Mechanical Restraint

Ordered at: Date**:**_____ Time: _____am/pm ***RN: to initiate a new Part II – "Observation and Care of the Patient" form (CVH-480b)***

Reorder Date of Seclusion/Restraint: _____ Time: _____am/pm

Original Start Date: _____ Start Time: _____am/pm

RN Summary Progress Note - Include a description of behaviors that continue to demonstrate imminent risk, and lack of response to interventions attempted during the previous 3 hours.

_____

_____

_____

Physical Assessment:_____

Vitals: [ ] Stable [ ] Other: _____

Circulation: [ ] Adequate [ ] Other:_____

Skin: [ ] Intact [ ] Other:_____

_____ _____ _____ _____am/pm
Signature (Assessing RN) Print Name Date Time

Procedure: (*Check ONE of the following categories: Seclusion OR Mechanical Restraint that is being continued beyond the original order*.)

Seclusion **Mechanical Restraint**

[ ] Locked [ ] 4 Point [ ] Soft Limb Holders [ ] Other: _____
[ ] Unlocked [ ] Mittens [ ] Posey Net

Patient notified of criteria for discontinuation? [ ] Yes [ ] No

MD Reassessment: Describe specific interventions utilized and patient response prior to this reassessment/reorder of seclusion/restraint. Include physical/medical assessment and note cautions or special interventions taken.

_____

_____

_____

_____

_____

_____

Psychotropic Medication Status During the Prior 3 Hours of Seclusion/Restraint (*Check all that apply*):

[ ] Routine psychotropic medication ordered and taken
[ ] Routine psychotropic medication ordered and NOT taken
[ ] No routine psychotropic medication ordered
[ ] PRN psychotropic medication taken
[ ] STAT/emergency psychotropic medication administered:
[ ] PO [ ] IM

Medical Director Notified? [ ] Yes: Time _____ am/pm [ ] No [ ] N/A

_____ _____ _____ _____ am/pm
Signature (Evaluating MD) Printed Name Date Time

I have reviewed the imminent need for reorder with the assessing RN as to the necessity of this intervention. [ ] Yes [ ] N/A
I have reviewed this seclusion/restraint episode for appropriateness and completeness of documentation.

_____ _____ _____ _____am/pm
Signature (Nursing Supervisor) Print Name Date Time

DISTRIBUTION: **Original – Chart** (*file in date order in the Progress Note Section*) **Photo Copy – Data Entry**