

PATIENTS' RIGHTS OFFICE
 SECLUSION AND RESTRAINT
 AUDIT FORM

CLIENT NAME: _____ DATE OF AUDIT: _____
 CHART/CASE #: _____ DATE OF ADMISSION: _____
 FACILITY: _____ DATE OF SECLUSION/RESTRAINT: _____

CHART/RECORD REVIEW

1. PHYSICIAN'S ORDER:	
A) TYPE	
B) MAXIMUM TIME	
C) WRITTEN []	
VERBAL []	
D) REASON	
E) THE POSITION THE PERSON RESTRAINED WAS PLACED IN? REF. CODE 1180.4 (e) 1	
2. LENGTH OF TIME IN: IN: _____ OUT: _____	
3. TIME OF PHYSICIAN'S ORDER: REASON/JUSTIFICATION:	
4. ATTEMPTS DOCUMENTED BY TO KEEP CLIENT IN LEAST RESTRICTIVE SETTING. (EXCEPTION: EMERGENCY SITUATION):	
5. ORDERS RENEWED: EVERY _____ HOURS	
6. PATIENT IN SECLUSION/RESTRAINTS OBSERVED EVERY 15 MINUTES:	

