**PART III – Reassessment by RN and MD/DO**

**Reorder of Seclusion/Restraint by MD/DO**

**Division:** [ ] Addiction Services  [ ] General Psychiatry  **Unit:**

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**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

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**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 2 hours.

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**Physical Assessment:**

- **Vitals:** [ ] Stable  [ ] Other:
- **Circulation:** [ ] Adequate  [ ] Other:
- **Skin:** [ ] Intact  [ ] Other:

**Signature (Assessing RN):**

- **Print Name**
- **Date**
- **Time**  am/pm

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

<table>
<thead>
<tr>
<th>Seclusion</th>
<th>Mechanical Restraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Locked</td>
<td>[ ] 4 Point Soft Limb Holders</td>
</tr>
<tr>
<td>[ ] Unlocked</td>
<td>[ ] Mittens Posey Net</td>
</tr>
</tbody>
</table>

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

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**MD/DO 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 noted on the initial Physician Face-To-Face.

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**Psychotropic Medication Status During the Prior 2 Hours of Seclusion/Restraint (Check all that apply):**

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

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

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**Signature (Evaluating MD/DO):**

- **Print Name**
- **Date**
- **Time**  am/pm

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**Signature (Nursing Supervisor):**

- **Print Name**
- **Date**
- **Time**  am/pm

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**I have reviewed the imminent need for reorder with the assessing RN as to the necessity of this intervention.** [ ] Yes  [ ] N/A

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**I have reviewed this seclusion/restraint episode for appropriateness and completeness of documentation.**

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**DISTRIBUTION:**

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