Positioning Devices, Self-Releasing Devices and Restraints Assessment

Name of Resident _____ Physician _____

Current Device _____Date _____

Prior Alternative Measures _____

Medical Diagnosis/Condition: _____

Physical and Mental Considerations

Balance	Yes	No	Vision	Yes	No
Postural Impairments			Legally Blind		
R.O.M.			**Mental Status**		
Upper Extremities WFL's			Alert		
Lower Extremities WFL's			Oriented		
Mobility			**Skin**		
Ambulatory			Intact		
Gait Disturbances			At Risk for Breakdown		
Assisted Device			**Medication that effect balance: (If yes list)**		
Specialized Seating System					
Independent with W/C Mobility					

Recommendations

Interdisciplinary Team Evaluation Date _____
Care Plan Updated Date _____
Resident will:

_____

_____

_____

_____

Is this a restraint? ____Yes _____No
If yes, complete "Restraint Review" on reverse side quarterly.
If yes, "Restraint Utilization Informed Consent" completed? _____Yes _____ No
If yes, a "Restraint" Care Plan will be initiated.

_____

_____
(Signature of Nurse) (Date)

_____
(Signature of Therapist) (Date)

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