* 3 5 2 4 9 *

ACT Health

Mechanical, Physical Restraint, or Forcible Giving of Medication Form

Complete details or affix label

URN: _____

Given name: _____

Given names: _____

Date: ____/____/_____ DOB: _____ Sex: _____

Legal Status of Consumer:

☐ **EA** ☐ **ED(3)** ☐ **ED(11)** ☐ **PTO** ☐ **CCO** ☐ **FPTO** ☐ **FCCO** ☐ **Correctional patient**

Type of restraint: ☐ Physical ☐ Mechanical

Reason for Restraint: Outline behaviours and events: _____

Nursing interventions used prior to restraint

Type of:

Mechanical restraint

☐ Wrists
☐ Ankles
☐ Chest

Physical Restraint (staff involved)

☐ Ward services ☐ Nursing staff ☐ Other – HSO4, Allied Health _____ ☐ Escort officer

Total number of staff involved: ☐

Restraint authorised ☐ Yes ☐ No Number of hours restrained: _____(for mechanical restraints only)

Restraint initiated by: _____ Physical restraint commenced (time):_____ ceased: _____

Mechanical restraint commenced: Date: ___/___/____ Time restraints ON: _____

Mechanical restraint ceased: Date: ___/___/____ Time restraints OFF: _____

Consultant Psychiatrist contacted: Time: _____ Name of Psychiatrist: _____

Was this medication given forcibly? ☐ Yes ☐ No Details *(Medication/dose/route/time given)*

☐ All necessary clinical documentation fully complete ☐ RiskMan complete

☐ Restraint register complete ☐ Forcible giving of medication register complete

Comments _____

Notice of restraint faxed to Public Advocate: Date: ___/___/____ Time: _____

Shift team leader signature **Print name** **Designation**

It is a requirement of the Mental Health Legislation that the Office of the Public Advocate of the ACT is notified in writing of mechanical, physical restraint, or forcible giving of medication events within 12 hours (fax: 6207 0688)

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