* 6 0 4 2 1 *

ACT Health

Seclusion/Confinement Observations

Period of Seclusion: _____ Hours

Date commenced: _____ **Time:** _____

Date completed: _____ **Time:** _____

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

Specialist authorising Seclusion/Confinement _____

Reasons for Seclusion/Confinement:	Known Medical Conditions/Allergies. E.g. Asthma, Diabetes

LEGAL STATUS (circle) ED3 ED-11 PTO	Date																							
TIME (Obs every 10 minutes)																								
Awake / **S**leeping																								
Sitting / **L**ying / **P**acing																								
Lucid / **C**rying / **R**anting																								
Aggressive: **V**erbal / **H**itting / **K**icking																								
Medication: *write in clinical file*																								
Dietary Intake: **D**rinks / **F**ood																								
Shower / **T**oilet																								
Medical review																								
Nurses Initials																								

Seclusion/Confinement form **completed:** ☐ **Yes** ☐ **No** **Date :** **Time:**

Shift Team Leader

Signature Print name Designation Date

Seclusion/Confinement Observations

LEGAL STATUS (circle) ED3 ED-11 PTO	DATE																							
TIME (Obs every 10 minutes)																								
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Seclusion/Confinement form **completed:** ☐ **Yes** ☐ **No** **Date :** **Time:**

Shift Team Leader	Signature	Print name	Designation	Date