OKLAHOMA DEPARTMENT OF CORRECTIONS Restraint Medical Flow Sheet

Inmate Name:	ODOC #:	Facility: _	Date A	oplied:				
Emergency application of restraints (valid for 4	hours only): 🛛 Y	es 🛛 No Release	signed: 🛛 Yes 🗖	No Date:				
Medical record reviewed by:		Clearance b	y:					
Special conditions of restraints? Yes No.	o If "Yes", de	efine:						
Reason for D Prevent injury to self D Pr restraint:	event injury to	others 🛛 Comba	tive / threatening	Other:				
Type of Soft Leather restraint:	Other:			_				
Applied to : 🛛 Right arm 🖓 Left arm	n 🛛 Right I	eg 🛛 🗖 Left leg						
Original Order Date: Time:	am / pm	Re-order Date:	Time:	am / pm				
Ordered By:	-							
		-						
Monitoring to occur at a minimum of every 2 hours. Document appropriate code.								
Time —	→							
Initials-	→							
Spoken to: C	ode							
Answers appropriately	1							
Answers inappropriately	2							
Refused to answer	3 ode							
Liquids: C Offered and accepted	1							
Offered and refused	2							
	ode							
Offered and accepted	1							
Offered and refused	2							
Bed pan/urinal: Co	ode							
Offered and accepted	1							
Offered and refused	2							
	ode							
No impairment due to restraints	1							
Impairment due to restraints - provider notified	2							
	ode							
Pink Pale	2							
Cyanotic	3							
	ode							
Good sensation	1							
Diminished	2							
Numb/tingling	3							
	ode							
massaged: (every 2 hours while awake and PRN for abnormal color of extremities or sensation)								
Restraints removed - ROM performed/skin	1							
massaged and restraints reapplied								
Inmate asleep	2							

Signature/Title	Initials	Signature/Title	Initials	Signature/Title	Initials