Date: ___________________________

Authorization is requested to place restraints on ____________________________________________
Inmate Name and ODOC Number

Restraints are needed for the following reason(s):  _____To prevent self-injury  _____To prevent injury to others

Describe earlier interventions and results: (5-ACI-6C-13M)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Who</th>
<th>When</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive Listening</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Verbal Intervention</td>
<td></td>
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<tr>
<td>Physical Activity</td>
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<tr>
<td>Change of Environment</td>
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<tr>
<td>Offering Nutrition, Water</td>
<td></td>
<td></td>
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<tr>
<td>Voluntary Options:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What

Requested by: ____________________________________________  (Name and Title)

Authorization to place inmate in therapeutic four/five point restraints is granted.  Yes ______  No ______

Date and time Psychiatrist authorized verbal __________________________________ Obtained by ____________

Date and time Psychiatrist authorized written __________________________________ Signature ________________

Date and time Facility head (or designee) authorized verbal __________________________ Obtained by ____________

Date and time Facility head (or designee) authorized written __________________________ Signature ________________

Psychiatrist Date/Time Facility head (or designee) Date/Time

Continued Placement 12 hour review: Date ______ Time ______ Obtained by __________________________

Psychiatrist __________________________ Facility head (or designee) __________________________

Continued Placement 12 hour review: Date ______ Time ______ Obtained by __________________________

Psychiatrist __________________________ Facility head (or designee) __________________________

Released from restraint or special comments: ____________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Psychiatrist Date/Time Facility Head(or designee) Date/Time

NOTE: ANY APPLICATION OF 4/5 POINT RESTRAINTS WILL BE IN ACCORDANCE WITH OP-050108, ATTACHMENT C

Original: Inmate Medical Record
Copy: Facility Head