OKLAHOMA DEPARTMENT OF CORRECTIONS
AUTHORIZATION FOR
APPLICATION OF THERAPEUTIC FOUR/FIVE POINT RESTRAINTS

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)

_____Supportive Listening Who _____ When _____ Results _____

_____Verbal Intervention Who _____ When _____ Results _____

_____Physical Activity Who _____ When _____ Results _____

_____Change of Environment Who _____ When _____ Results _____

_____Offering Nutrition, Water Who _____ When _____ Results _____

_____Voluntary Options: Who _____ When _____ Results _____

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

Original: Inmate Medical Record
Copy: Facility Head