



ALASKA DEPARTMENT OF CORRECTIONS

Therapeutic & Medical Restraint Order/Release Form 807.03A DATE: _____

Offender Information

Offender Name:		ACOMS:	
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Least Restrictive Alternatives

<input type="checkbox"/>	Verbal counseling	<input type="checkbox"/>	Removing stimuli	<input type="checkbox"/>	Single housing cell
<input type="checkbox"/>	Suicide precautions	<input type="checkbox"/>	Psychotropic medication	<input type="checkbox"/>	Interdisciplinary Intervention Plan
<input type="checkbox"/>	Other:				

Therapeutic Restraint Order

<input type="checkbox"/>	Initiate therapeutic restraints	<input type="checkbox"/>	Initiate medical restraints	<input type="checkbox"/>	Release from restraints
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Justification

<input type="checkbox"/>	Imminent risk of harm to self	<input type="checkbox"/>	Imminent risk of harm to others	<input type="checkbox"/>	Prevent interruption of medical treatment
<input type="checkbox"/>	Other				

Authorization

	Name & Title	Date	Time
Requestor			
Psychiatric Provider VERBAL			
Psychiatric Provider WRITTEN			
Designee (only when psychiatric provider unavailable)			

Therapeutic Restraint Type

<input type="checkbox"/>	Ankle	<input type="checkbox"/>	Posey mitts	<input type="checkbox"/>	Wrist/waist
<input type="checkbox"/>	Helmet	<input type="checkbox"/>	Restraint chair	<input type="checkbox"/>	Restraint Bed

Release Criteria

<input type="checkbox"/>	No imminent risk of harm to self	<input type="checkbox"/>	No imminent risk of harm to others	<input type="checkbox"/>	Lesser restrictive alternatives are effective and/or more appropriate
<input type="checkbox"/>	Offender aware of release criteria	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Additional Comments

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Notification

Title	Signature	Date	Time
Superintendent			