STICKER

Name:_____
MRN:_____
DOB:_____

Sample Refraint™ Log

Order Date/Time:_____ **Start Time:**_____ **End Time:**_____

Ordering Provider:_____

Frequency: Continuous
Duration: 1 Day
Priority: Routine

Refraint reason:

☐ **Allowance of mobility and freedom that avoids entanglement in attached vital tubes, catheters, and/or other medical equipment which would otherwise require restraint/immobilization.**

☐ **Other:**_____

Refraints must be completely removed when patient no longer meets criteria to require them. Orders must be renewed every calendar day.

Extremity ☐ **Bilateral Upper Limbs** ☐ **Right Upper Limb Only** ☐ **Left Upper Limb Only**

Starting Bed Strap ☐ **No Bed Strap** ☐ **Exercise Bed Strap** ☐ **Restraint Bed Strap**

Bed Strap Rationale

Exercise Strap: ☐ **Resistance exercise** ☐ **Low Level restraint***

****Restraint Strap:**

☐ **Dislodgement of device that may threaten life and/or interferes with medical devices/equipment - (e.g., pulling at or removing lines, tubes, catheters)**

☐ **Observed actions or behaviors that place patient at high risk for injury - (e.g., dangerous movement, procedure requiring stillness)**

***IF THE EXERCISE BED STRAP IMMOBILIZES THE PATIENT RATHER THAN ALLOWING RESISTANCE EXERCISE, THEN IT IS A *RESTRAINT* AND MUST BE DOCUMENTED AS SUCH**

****IF *RESTRAINT* STRAP APPLIED, REVERT TO YOUR INSTITUTION'S *RESTRAINT* FORM**