(Check one)

☐ **Seclusion** ☐ **Restraint**

Consultation Request Form

Addressograph

Note: *Patients secluded and/or restrained 3 times or more must have a consultation form completed and forwarded to the Medical Director's office.*

Patient Diagnosis: ***Axis I*** _____

Axis II _____

Axis III _____

Current Medication:

_____

_____

_____

_____

_____

Reason for Seclusion/Restraint:

1st Time *(Date)* _____ **Reason:** _____

2nd Time *(Date)* _____ **Reason:** _____

3rd Time *(Date)* _____ **Reason:** _____

Requested by: _____ _____ _____

Assigned Nurse ***Attending Physician*** ***Date***

Recommendations:

_____

_____

_____

_____

_____ _____

Medical Director/Designee ***Date***

Original (Medical Records) *Pink (Medical Director)*