CRER App. No.: IRB-2027-654V1 9.1.2025

HOSPITAL AUTHORITY

UNITED CHRISTIAN HOSPITAL

PHYSICAL RESTRAINT ASSESSMENT FORM

(For Study use ONLY)

PIN: _____

Date:									
Time:									
Assessment *(please fill the "Letter" in or tick the appropriate box as below)*									
Level 1. Mental / Behavioural level									
(1) O - Orientated; I - Disoriented; R - Restless; A - Aggressive									
Level 2. Device level									
(2a) Oxygen therapy									
(2b) Wound with dressing									
(2c) Drain / Tube / Catheter									
(2d) Peripheral Intravenuous catheter									
(2e) Treatment infusion									
(2f) Physiological monitoring leads									
(2g) Others ( )									
(2h) Not applicable									
Level 3. Mobility level									
(3) I - Independent; A - Ambulatory with aid(s); D - Dependent									
Level 4. Consequence level [Indication(s) for Physical Restraint Use]									
(4a) Interrupt essential treatment or monitoring									
(4b) Injury to self									
(4c) Injury to others									
(4d) High risk of Falls									
Level 5. Alternative level (Please consider NOT to give physical restraint if either one of the alternatives is "V")									
(5a) Accompany care									
(5b) Reality orientation periodically									
(5c) Use of sensor pad(s)									
(5d) Put patient within nurse station's vicinity									
(5e) Administer antipsychotic medications as prescribed									
(5f) Medication review *(During the initial restraint or as necessary)*									
(5g) Use disguised tubes, lines and devices (e.g., covered by clothing)									
(5h) Other: ( )									
(5i) Not applicable									