Delaware GER - Restraint Other

Restraint Type: ☐ Chemical ☐ Mechanical ☐ Physical ☐ Other:_____
Begin Time:* _____am / pm End Time:* _____am / pm End Date:_____
Specific Location:
☐ Activity Area ☐ Bathroom ☐ Bedroom ☐ Dining Room ☐ Hallway ☐ Kitchen ☐ Living Room
☐ Outdoors ☐ Recreation Area ☐ Staircase ☐ Unknown ☐ Other:_____
Date of last medical exam:_____
Death determined by (Physician/Specialist):_____
Restraint Summary:_____
_____
_____
Witness 1:_____
Witness 2:_____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

Note:- Required fields are marked with an asterisk (*)