

**OKLAHOMA DEPARTMENT OF CORRECTIONS
AUTHORIZATION FOR
APPLICATION OF THERAPEUTIC FOUR/FIVE POINT RESTRAINTS**

Date: _____

Authorization is requested to place restraints on _____
Offender Name and DOC Number

Restraints are needed for the following reason(s): ___ To prevent self-injury ___ To prevent injury to others

Describe earlier interventions and results: (4-4405M)

___ Supportive Listening	Who _____	When _____	Results _____
___ Verbal Intervention	Who _____	When _____	Results _____
___ Physical Activity	Who _____	When _____	Results _____
___ Change of Environment	Who _____	When _____	Results _____
___ Offering Nutrition, Water	Who _____	When _____	Results _____
___ Voluntary Options: What _____	Who _____	When _____	Results _____

Requested by: _____
(Name and Title)

Authorization to place offender in therapeutic four/five point restraints is granted. Yes _____ No _____

Date and time *Psychiatrist* authorized **verbal** _____ Obtained by _____

Date and time *Psychiatrist* authorized **written** _____ Signature _____

Date and time *Warden (or designee)* authorized **verbal** _____ Obtained by _____

Date and time *Warden (or designee)* authorized **written** _____ Signature _____

_____	Date/Time _____	_____	Date/Time _____
Psychiatrist		Warden (or designee)	

Continued Placement 12 hour review: Date _____ Time _____ Obtained by _____

Psychiatrist _____ Warden (or designee) _____

Continued Placement 12 hour review: Date _____ Time _____ Obtained by _____

Psychiatrist _____ Warden (or designee) _____

Released from restraint or special comments: _____

_____	Date/Time _____	_____	Date/Time _____
Psychiatrist		Facility Head(or designee)	

NOTE: ANY APPLICATION OF 4 or 5 POINT RESTRAINTS WILL BE IN ACCORDANCE WITH OP-050108, ATTACHMENT C

Original: Offender Medical Record
Copy: Warden