Patient: _____

Service: _____ Date of Birth: ___/___/____

PATIENT'S LABEL

PATIENT RESTRAINT FORM

I state for all due purposes that I have been duly informed, in clear and objective language, of the need and maintenance of the measures adopted in the **patient restraint procedure**.

I have received all the information regarding the indications, benefits, and risks of not using **patient restraint**. I had the opportunity to have all my questions answered regarding the procedure before signing this document.

After understanding the explanations I received, having all my questions answered and being fully satisfied with the information received, I choose to:

( ) **Not authorize restraint**, even though I am aware of the risks, personally and individually accepting all consequences and responsibilities regarding my refusal.

( ) **Authorize restraint**.

Salvador, _____ 20 ____ _____:_____(hh:min)

_____

Representative / Legally Responsible Person:

Name: _____

ID:_____Relationship: _____

STATEMENT OF PROFESSIONAL

I state that I have explained to the responsible person/ Legally Responsible Person the entire **patient restraint procedure**, treatment, to which the above-mentioned patient is subject, its recommendations, benefits, and risks, having answered any questions asked by them, as well as about the risks related to which they will be exposed based on their decision.

_____

Signature /Stamp of professional