

Physical and Chemical Restraints – Form/Questionnaire

This form/questionnaire will assist you or your attorney in evaluating your physical and/or chemical restraint concerns at a particular nursing facility.

Your Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail address: _____ Home Phone: _____

Business Phone: _____ Additional: _____

Name of party at nursing home (if different than above): _____

Relationship to party at nursing home (if applicable): _____

Name of Nursing Home: _____

Address of Nursing Home: _____

City: _____ State: _____ Zip: _____

Please complete the following to the best of your ability:

Approximately how many reside at this facility?

- 10 or fewer
- 10 – 50
- 50 – 100
- greater than 100

What is the approximate number of staff?

- 10 or fewer
- 10 – 50
- 50 – 100
- greater than 100

Please place an “X” next to any type of physical restraint that you have witnessed being used, or has been used on you, or a loved one, at the above mentioned nursing facility.

- wrist restraints
- hand mitts
- ankle restraints
- restricting vests

- restrictive wheelchair attachments/restraints
- bed rails
- tightly tucked bed sheets
- other(s)

Please describe: _____

In the space below, please describe any type of chemical restraint that has been used on you, or a loved one, at the above mentioned nursing facility.

Please list any physical or psychological justification(s) that were given to you, or a loved one, by the facility in an attempt to justify the use of physical or chemical restraint(s).

Please briefly describe below why you feel that any physical or chemical restraint that has been used on you, or a loved one, is (or was) unnecessary.

Additional comments:
