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## General Public Restraint or Positioning Device Authorisation

We suggest the following occupations are authorised to sign this form: Occupational Therapist, Physiothrapist, Clinical Nurse Manager, Registered Nurse, Doctor, or other suitably qualified healthcare person

This authorisation letter is to confirm that *(insert patient's name)* \_\_\_\_\_  
is authorised by me to use the *(insert product name)* \_\_\_\_\_.

**Warning:** Only use a restraint or positioning device if all other alternatives have been tried. Restrained patients should be kept under observation, as their behavior may alter and another restraint or positioning device may be more appropriate. Restraint or positioning devices may be a prescribed item. The wrong restraint or positioning device, or the correct restraint or positioning device incorrectly fitted, can cause injury or death.

Family and/or Carers must be properly trained in fitting the restraint or positioning device.

### Authorised by:

Name \_\_\_\_\_

Job Title \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_

Please email this to:  
[sales@pelicanmanufacturing.com.au](mailto:sales@pelicanmanufacturing.com.au)