Eastern Idaho Regional Medical Center
Behavioral Health Center

Teton Peaks

# Communication/Correspondence Restriction

Under specific conditions, communications shall be restricted requiring the patient and parent/guardian(s) signatures prior to being restricted. This restriction will occur only if the treatment team determines that the communication is detrimental to the patient's treatment, threatening, or counter-productive. See the Behavioral Health Center policy on Patient Mail.

Reasons for restriction:

I have read and understand the BHC policy M-1 on "Patient Mail." I am aware that when deemed necessary by the treatment team and/or parent/guardian, that communication may be counter-productive to treatment, thus causing communication to be restricted.

Effective Date _____ Date Ending _____

_____
Patient signature
**If patient refuses to sign, then there must be a staff witness that the restriction was reviewed with the patient.*

*Witness Name Position Date Time

Parent/guardian signature
***If parent is unable to sign, two staff must witness and sign that verbal permission was granted.*

**Witness Name Position Date Time

**Witness Name Position Date Time

Therapist Signature Date Time