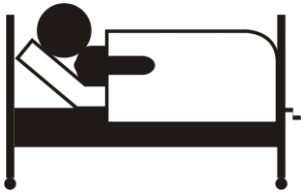
Patient Name: _____

GRACE HOSPITAL

PATIENT HANDLING & MOVEMENT SIGN



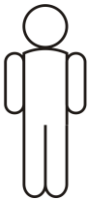
BED REST

BRACES OR SPLINTS REQUIRED

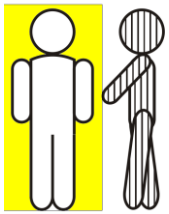
- ☐ CANE
- ☐ CRUTCHES
- ☐ STRETCHER
- ☐ TRANSFER BOARD
- ☐ WALKER_____(TYPE)
- ☐ WHEELCHAIR
- ☐ OTHER_____

_____

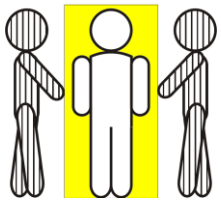
BED MOBILITY



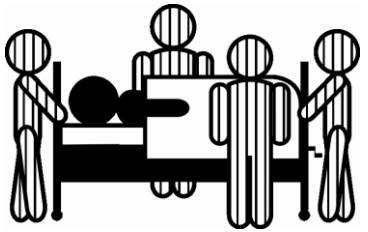
INDEPENDENT
(NO ASSISTANCE REQUIRED)



ONE PERSON WITH SLIDERS

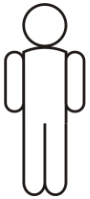


TWO OR MORE PERSON
WITH SLIDERS

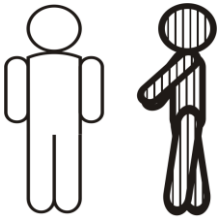


LOG ROLL

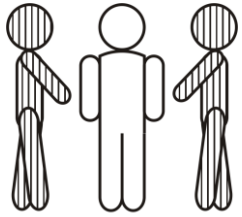
TRANSFERS



INDEPENDENT
(NO ASSISTANCE REQUIRED)

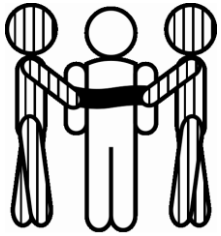


STAND BY ASSIST

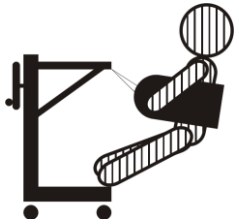


SUPERVISED
(TWO PERSON STANDBY ASSIST)

MINIMAL
(ONE PERSON WITH TRANSFER BELT)



MINIMAL
(2 PERSON WITH TRANSFER BELT)



SIT-STAND LIFT

FULL MECHANICAL LIFT

SPECIAL BED MOBILITY/ TRANSFER INSTRUCTIONS

_____

_____

_____

- ☐ SEE NURSE BEFORE PROCEEDING