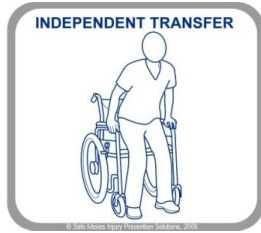


TRANSFER ABILITY



Date: _____



Date: _____



Date: _____



Date: _____



Date: _____



Date: _____



Date: _____



Date: _____

BED MOBILITY



Date: _____



Date: _____



Date: _____



Date: _____



Date: _____



Date: _____



Date: _____

REPOSITIONING NEEDS:
 Tilt wheelchair
 Turning routine bed

MOBILITY

DATE: _____

- Walks Independent
- Walking Supervised
- Walks 1 Assist
- Walks 2 Assist
- Walking Exercise Distance _____

- Walking Aides:
 - None
 - Cane
 - Walker
- High Risk for Falls

- Wheelchair Propulsion:
 - Foot Propels
 - Hand Propels
 - Assist to Propel
 - Power Wheelchair

- Range of Motion Exercise:
 - Active/Assisted
 - Passive
- Brace/Splint Required

SPECIAL CONSIDERATIONS: