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: