



MOBILITY RECORD

Level of Client Mobility Risk Assessment:

I - Initial R - Re-assessment

Key:

Initial if no risk









✓ if no risk but written note required

X if risk, written note required

NA or / if area of risk not applicable

Year: _____		Month/Day												
		Time												
		Level of Assessment												
PART A - Verbal, Written and Observation	Health Information	Communication Risk Factors Impacting Mobility												
		Is able to communicate and understand												
		Vision/hearing difficulties addressed (see device/s)												
		Cognitive Risk Factors Impacting Mobility												
		Is able to remember instructions related to the move												
		Is able to judge own capabilities in moving												
		Is able to make decisions												
		Emotional/Behavioral Risk Factors Impacting Mobility												
		Displays stable moods												
		Demonstrates predictable/cooperative behaviours												
		Medical Risk Factors Impacting Mobility												
		Is able to participate in move despite medical condition												
		Is aware of own body position in the environment												
		Is able to move with attachments/appliances												
		Is able to move despite pain/fatigue												
Is able to participate in move despite medication effects														
Currently uses mobility assistive devices (see device/s)														
PART B - Testing and Observation	Pre-mobilization Testing	Physical & Functional Risk Factors Impacting Mobility												
		Can grip, push, pull in handshake approach	Rt											
			Lt											
		Can lift leg, bend and straighten knee	Rt											
			Lt											
		Can move foot up and down at the ankle	Rt											
		Lt												
	Can bridge													
	Can roll from side to side in bed	Rt												
		Lt												
	Sitting Tests	Can achieve sitting position												
		Can sit unassisted for 20 seconds												
		Can right self when gently tipped in all four directions												
	Standing Tests	Can position self in preparation for standing												
		Can lift body weight off buttocks/thighs												
		Can stand independently												
		Can remain standing for 20 seconds												
		Balanced lifting one arm at a time to front and side												
	Walking Tests	Can shift weight from one foot to another												
		Can walk (or shuffle) on the spot												
Can walk (or shuffle) 3 steps forward and 3 steps back														

Continue to next section

		Date initiated	ID	Date disc	ID		Date initiated	ID	Date disc	ID	
Mobile	Independent  <input type="checkbox"/> Bed <input type="checkbox"/> Bath <input type="checkbox"/> Toilet					Mobility Device					
						Walker					
						Cane					
					Wheelchair						
						Sensory Device	Date initiated	ID	Date disc	ID	
						Glasses: <input type="checkbox"/> Regular <input type="checkbox"/> Reading					
Mobile	Guided  <input type="checkbox"/> Bed <input type="checkbox"/> Bath <input type="checkbox"/> Toilet					Hearing aid(s): <input type="checkbox"/> Lt <input type="checkbox"/> Rt					
						Transfer Device	Date initiated	ID	Date disc	ID	
Standing Transfers	One-worker with belt  <input type="checkbox"/> Bed <input type="checkbox"/> Bath <input type="checkbox"/> Toilet										
							Reposition Device	Date initiated	ID	Date disc	ID
Standing Transfers	Two-workers with belt  <input type="checkbox"/> Bed <input type="checkbox"/> Bath <input type="checkbox"/> Toilet					Other	Date initiated	ID	Date disc	ID	
						Wall Bar x 1					
						Wall Bar x 2					
					Wall Bar x 3						
					Tub Clamp						
					Tub Seat						
Mechanical Lifts	Sit/Stand  <input type="checkbox"/> Bed <input type="checkbox"/> Bath <input type="checkbox"/> Toilet Specify*					Sask-a-Pole					
						Toilet Arm Rests					
						Rubber Bath Mat					
					Telephone Shower						
Mechanical Lifts	Total/Ceiling Track/Tub  <input type="checkbox"/> Bed <input type="checkbox"/> Bath <input type="checkbox"/> Toilet Specify*					*Mechanical Lift Sling/harness Type and Size					
						Ensure compatibility	Date initiated	ID	Date disc	ID	
Reposition	Reposition  Indicate repositioning device required					<input type="checkbox"/> Specialized Assessment Requested					
							Date initiated	ID	Date disc	ID	
Bed Rest	Bed Rest 					1. Identify the Area of Risk for the specific client					
						2: Document additional risks identified					
						3: Specialized Assessment Team determines solution					
					4: Consider including other professionals						
					5: Team documents and communicates specialized technique and equipment to circle of care; ensure documentation is in the client chart (e.g., attach to current mobility record)						
					6: Workers are trained and training is documented.						