

# Fall Prevention: Mobility Guide

Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_

PT name: \_\_\_\_\_ Pager #: \_\_\_\_\_





## Is the patient able to transfer or walk independently?

- Yes** - Transfer to:  wheelchair  bed  toilet  shower OR walk  on unit  within facility  
 **No** - Use gait belt and DO NOT leave patient alone in the bathroom.

## Is the family/caregiver able to transfer or walk the patient?

- Yes** - Who? \_\_\_\_\_ Can transfer/ walk patient to:  wheelchair  bed  toilet  shower  
 **No** - Call for assistance. OR walk:  on unit  within facility

## Fall Risk Factors and Safety

 <b>History of fall</b>	<b>Date of last fall:</b> _____	 <b>Exit Alarm (Bed / Chair)</b>		 <b>Gaitbelt</b>	Patient safe to sit on the edge of the bed unsupervised? <input type="checkbox"/> Yes <input type="checkbox"/> No
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## Assistance

- Level of assist:**  Set up only  Supervision  Contact guard/minimal assist  
 Moderate assist  Maximum assist  Total assist  2 person assist



**Walking**



**Stand Pivot**



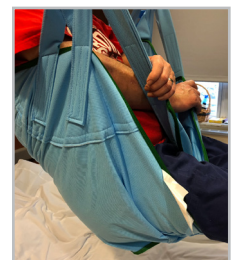
**Modified Stand Pivot**



**Slide Board**



**Stand Assist Device**



**Ceiling/ Floor Lift**

**Direction of transfer:**  Right side  Left side

**Remove arm rest:**  Yes  No

**Weight Bearing Status / Precautions:** \_\_\_\_\_

**Other:** \_\_\_\_\_

**Need for device:**  Yes  No If yes, what device? \_\_\_\_\_

