HFMSE

STEER COAV101B12301 Quality Check Video Observation Form

Reviewer Name:	
Date of QC review (DDMMMYYYY):	
Site Number:	Patient ID:
Visit Name:	Visit Date:
Clinical Evaluator Name:	

HFMSE Item	Appropriate Administration NA = Not Administered	Suggestions for Improvements *Required if No is selected*	Retraining Recommended
Item 1: Plinth /chair sitting	☐Yes ☐No ☐NA		☐
Item 2: Long sitting	☐Yes ☐No ☐NA		☐
Item 3: One hand to head in sitting	☐Yes ☐No ☐NA		☐
Item 4: Two hands to head in sitting	☐Yes ☐No ☐NA		☐
Item 5: Supine to sidelying	☐Yes ☐No ☐NA		☐