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| NightingaleHammerson_logo_CMYK | | **C14b – PHYSIOTHERAPY ASSESSMENT** | |
| **RESIDENT’S NAME:**  **UNIT:** |  | **DATE OF ADMISSION:**  **D.O.B:** |  |

**PHYSIOTHERAPY ASSESSMENT**

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| --- | --- |
| **Current conditions affecting mobility and function:** | |
| **Mobility aid**:  **Level of independence:** | **Safe distance:**  **Method of transfer:** |
| **History of Falls:** | **Risk of falls: HIGH MED LOW**  **Reason:**  **Advice:** |
| **Behaviours & motivation:** | |
| **Other relevant info:** | |
| **Resident’s personal goals (aspirations around functional independence, health and well-being):** | |
| **Physiotherapy intervention:** | |
| **Consent:** | |

**Physiotherapist: Designation:**

**Signature: Date of this assessment:**