Ambulation Evaluation – Restorative Nursing

Resident_____ Date_____

Date of referral:_____

Previous Therapy_____

Results:_____

Previous Restorative program_____

Results:_____

Recommendations from therapy / physician_____

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Balance / Gait Assessment date / results_____

_____

Strength / Endurance Assessment date / results_____

_____

Assistive Device / Appliance Assessment date / results_____

_____

Fall History

____ Fell in past 30 days ____ Fell in past 31-180 days ____ Multiple falls

____ No history of falls ____ Assessed to be at risk for falls

Use of Restraint

____ None ____ Waist ____ Trunk ____ Geri chair Other_____

Medications

____Antipsychotics ____Antianxiety/hypnotics ____Antidepressants

____Cardiovascular medications ____Diuretics Other_____

Internal Risk Factors

____Cardiac dysrhythmia / Pacemaker ____Loss of arm or leg movement

____Decline in functional status ____Incontinence ____Hypotension ____CVA

____Hemiplegia/Hemiparesis ____Parkinson's ____Seizure disorder ____Syncope

____Chronic/Acute condition makes unstable Other_____

Orthopedic

____Joint pain ____Arthritis ____Missing limb / Amputation

____ Hip fracture ____Osteoporosis ____Limited Range of Motion

Perceptual

____ Hearing impaired ____ Vision impaired ____ Dizziness/Vertigo

Other_____

Psychiatric / Cognitive

____ Memory problem ____ Sequencing problem ____ Decision-making impaired

____ Attention deficit ____ Lack of safety awareness ____ Alzheimer's / Other Dementia

Motivated: ____ Very ____ Somewhat ____ Not at all ____ Psychiatric diagnosis

Other_____

Present Ambulation Status

____ Independently ____ Assist of one ____ Assist of two ____ Partial weight bearing

____Unable to ambulate ____Gait belt ____Walker ____Rolling walker ____Cane

____Quad cane ____Crutches ____Handrails ____Walks behind wheelchair

Distance: ____2 feet ____5 feet ____10 feet ____15 feet ____20 feet Other_____

____Daily ____ Twice per day ____Three times per day Other_____

Goal for Ambulation Status

____ Independently ____ Assist of one ____ Assist of two ____ Partial weight bearing

____Unable to ambulate ____Gait belt ____Walker ____Rolling walker ____Cane

____Quad cane ____Crutches ____Handrails ____Walks behind wheelchair

Distance: ____2 feet ____5 feet ____10 feet ____15 feet ____20 feet Other_____

____Daily ____ Twice per day ____Three times per day Other_____

Notes

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Evaluation completed by_____ Date_____