

Appendix C – Individual Client Mobility needs Assessment Tool

Unit/Department:										Date:								
Assessment Completed by:										Number of Clients Assessed:								
Client Name/ Location		Independent	Non-Weight-Bearing Procedures				Weight-Bearing Procedures			Reposition			Potential Barriers					
			Lift (insert # of lifts) and/or Lateral Slide (insert # of lateral slides)				Transfer (insert # of transfers)			(insert # of repositions)			(check if applicable)					
		Use Checkmark	Manual ^a	Mech. ^b	Lateral or Slide	Device Name	One Person	Two People	Device (Name)	Bed	Wheel chair	Device Name	1	2	3	4	5	Other
Mr. A	Days																	
	After- noons																	
	Nights																	
Mr. B	Days																	
	After- noons																	
	Nights																	
Mr. C	Days																	
	After- noons																	
	Nights																	
Mr. D	Days																	
	After- noons																	
	Nights																	

a. Manual – the entire weight of the client is lifted by workers
b. Mechanical – the entire weight of the client is lifted by a device

Legend for Potential Barriers

1. Environmental
(e.g. room size, compatibility between furniture and a lift)
2. Client resistance
3. Family resistance

4. Required equipment unavailable
 5. Known aggressive behaviour
- Other – Note any other barriers that impact on the safe handling of client