Appendix D – Unit/Departmental Client Mobility needs Assessment Summary Tool

Unit/Department:			
Date:			
Assessment Completed by:			
Number of Clients Assessed:			
Lifts and Lateral Slides (Non-Weight-Bearing)	**Days**	**Afternoons**	**Nights**
Total number of manual lifts[a]			
Total number of mechanical lifts[b]			
Total number of lateral slides			
Specify the names of the device and the frequency of use			
Transfers (Weight-Bearing)	**Days**	**Afternoons**	**Nights**
Total number of one-person transfers			
Total number of two-person transfers			
Specify the types of transfer devices being used and their frequency			
Repositioning	**Days**	**Afternoons**	**Nights**
Total number of bed repositions			
Total number of wheelchair repositions			
Specify the types and frequency of use of repositioning devices			
Potential Barriers	**Provide explanation**		
Specify the Environmental barriers			
Specify the Client/Family Resistance barriers			
Specify the Equipment barriers			
Specify the Aggressive barriers			
Specify other barriers			

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

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