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| --- | --- | --- |
| **Patient Name:**  | **Rm#:**  | **Code Status:**  |
| **Column 1 Codes: Self- Performance**1. Independent (no help from staff)
2. Supervision (no touch, but verbal cues and encouragement
3. Limited assistance (minimal touch)
4. Extensive assistance (weight bearing, 1 person assist)
5. Total Dependence (2 person assist)
6. 5- Activity did not occur
 | **Column 2 Codes: Support Provided**1. No set-up, no physical help
2. set-up
3. 1 person physical assist
4. 2 or more people physical assist
5. activity did not occur
 |
| **Section**  | **Date:**  | **Date:** | **Date:** |
| **1** | **2** | **Time/Initial** | **1** | **2** | **Time/Initial** | **1** | **2** | **Time/Initial** |
| **Bed Mobility**  | **Right Side** |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
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| **Back Side**  |  |  |  |  |  |  |  |  |  |
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| **Left Side** |  |  |  |  |  |  |  |  |  |
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| **Transfer out of bed to** | **Chair** |  |  |  |  |  |  |  |  |  |
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| **W/C** |  |  |  |  |  |  |  |  |  |
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| **Commode** |  |  |  |  |  |  |  |  |  |
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| **Dressing** | **Pajamas** |  |  |  |  |  |  |  |  |  |
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| **Clothes** |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |
| **Bathing:**  | **Shower** |  |  |  |  |  |  |  |  |  |
| **Bed Bath** |  |  |  |  |  |  |  |  |  |
| **Partial Bath** |  |  |  |  |  |  |  |  |  |

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| **Section**  | **Date:** | **Date:** | **Date:** |
| **1** | **2** | **Time/Initial** | **1** | **2** | **Time/Initial** | **1** | **2** | **Time/Initial** |
| **Personal Hygiene** | **Hair Care** |  |  |  |  |  |  |  |  |  |
| **Teeth** |  |  |  |  |  |  |  |  |  |
| **Shaving** |  |  |  |  |  |  |  |  |  |
| **Hands/Face** |  |  |  |  |  |  |  |  |  |
| **Toileting** | **Toilet** |  |  |  |  |  |  |  |  |  |
| **Commode** |  |  |  |  |  |  |  |  |  |
| **Brief**  |  |  |  |  |  |  |  |  |  |
| **Catheter** |  |  |  |  |  |  |  |  |  |
| **Ostomy** |  |  |  |  |  |  |  |  |  |
| **Column 1 Codes:** 1. Small
2. Medium
3. Large
4. Extra Large
 | **Column 2 Codes:** C- ContinentIT- Incontinent smallIN- Fully IncontinentO- Did not go |
| **Incontinence** | **Bowel** |  |  |  |  |  |  |  |  |  |
| **Bladder** |  |  |  |  |  |  |  |  |  |
|  | **Vomit** |  |  |  |  |  |  |  |  |  |
| **Column 1:** Food percentage**Column 2:** Percentage below 50% reported: Yes, No or N/A |
| **Food Intake** | **Meals** |  |  |  |  |  |  |  |  |  |
| **Snacks** |  |  |  |  |  |  |  |  |  |
| **Fluid Intake:** | **Water** |  |  |  |  |  |  |  |  | **Total:** |
| **Juice** |  |  |  |  |  |  |  |  | **Total:** |
| **Milk** |  |  |  |  |  |  |  |  | **Total:** |
| **Coffee/Tea** |  |  |  |  |  |  |  |  | **Total:** |
| **Other:** |  |  |  |  |  |  |  |  | **Total:** |

**Vitals Signs should be recording on Vital Sign Flow sheet.**

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| **Date:**  | **Initial:**  | **Signature:**  |
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