**Patient Risk Assessment for Safe Handling and Movement**

Is the patient able to move independently? If yes, then sign and date form here. If no, complete assessment below.

Date: \_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight-Bearing Capability

* Full
* Partial
* None

Communication and Behavior

Does the patient understand instructions?

* Yes
* No

Is the patient cooperative?

* Yes
* No

Physical Limitations

(such as surgery, sedation, impaired hearing or sight, loss of limb use, stroke, etc.)

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**Required Level of Assistance**

* High – Completely dependent, patient requires nurse to lift more than 35 lbs. of the patient’s weight, or patient is unpredictable in the amount of assistance offered. Assistive devices should be used.
* Medium – Requires some assistance. Caregiver is required to lift no more than 35 lbs. of the patient’s weight
* Low – Requires no hands-on assistance. Patients performs task with or without staff assistance, and with or without assistive devices.

Environmental Constraints

Confined space, non-adjustable equipment, floors, ramps, etc. issues?

* Yes
* No

If yes, please provide details.

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Medication

Is medication relevant to moving and handling?

* Yes
* No

If yes, please provide details.

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History of Falls

* Yes
* No

If yes, provide description and assessment details.

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Date: \_\_\_\_\_\_\_\_\_ Assessor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_