CVH-334a **CONNECTICUT VALLEY HOSPITAL**

Rev. 4/08 P**HYSICAL THERAPY SCREENING –** [ ] Post Fall Assessment [ ] Fall Risk [ ] New Admission

[ ] General Psychiatry Division Name:_____

[ ] Whiting Forensic Division

[ ] Addiction Services Division MPI#: _____*Print or Addressograph*

Ward/Unit:_____Date of Admission_____Date of Birth_____Age_____

Medical/ Psychiatric History: Recent Medication Change: [ ]Yes [ ]No	Visual Impairment [ ]Yes [ ]No Corrective eyewear worn ambulating? [ ]Yes [ ]No Appropriately fitting footwear? [ ]Yes [ ]No Fall History with dates/frequency: Serious injury sustained: [ ]Yes [ ]No

PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

Dep=Dependent; Max=Maximal Assist; Mod=Moderate Assist; Min=Minimal Assist; CG=Contact Guard; S=Supervision; I=Independent If assisted please indicate by number of persons needed.

FUNCTION	DESCRIPTION	Dep	Max	Mod	Min	CG	S	I
Bed Mobility	Moves in bed including Supine ←→ sitting							
Transfer (exclude bath/toilet)	Moves to/from varied surfaces							
Toilet transfers	Moves on and off toilet							
Mobility in Room, Unit &Hallway [ ] walking [ ] wheelchair	Moves in room							
Mobility off Unit [ ] walking [ ] wheelchair	Travels to/from distant sites [ ] uses elevator [ ] stairs							

TEST FOR BALANCE:

Key: 0=safe and independent
1=Unsteady, regains balance, no assist
2=Partial physical assist
3=Unable

Berg Balance Test: /56 [ ] not tested	**GRADE**
1. Balance in sitting, trunk control	
2. Static standing balance	
3. Dynamic standing balance	

RANGE OF MOTION/STRENGTH:

Key: A: ROM 0=No Limitation 1=Limited on one side 2=Limited bilaterally
B: Muscle strength 0= normal: 4/5 1=fair: 3/5 2=poor: 2/5 or less

	A	**B**
Lower extremities		
Upper extremities		
Trunk		

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MODES OF LOCOMOTION (check if applicable):
[ ]Walker/crutch/cane [ ] Other person wheeled
[ ]Wheels self [ ]Wheelchair main form of locomotion
[ ]Ambulates independently [ ] Gait belt
[ ] No assistive device

MODES OF TRANSFER(check if applicable):
[ ]Independent [ ]Staff assist of_____people
[ ]Mechanical lift: [ ]Sara [ ]Marissa [ ] Volaro
Transfer aid: [ ]brace [ ]sliding board [ ]trapeze [ ]bedrail

Fall Prevention Education Provided: [ ] Yes [ ] No _____

Recommendations: [ ] Skilled Physical Therapy Evaluation recommended [ ] MD referral [ ]No Treatment Recommended

_____
_____
_____
_____
_____
_____
_____

Anticipated Equipment Needs:_____**Fall Risk [ ]Yes [ ] No**

_____ _____

Signature/Title of Therapist Date

Chronologically place in Physical Health Progress Note Section accompanying Post Fall Assessment Form (CVH-575).