

Bed Mobility Screen

Facility: _____

Resident: _____ Date: _____

Resident was screened for bed mobility skills.

Per screen:

- ☐ Resident requires repositioning rails for bed mobility
 - ☐ Left Side
 - ☐ Right Side

- ☐ Resident requires staff assist and repositioning rails for bed mobility
 - ☐ Left Side
 - ☐ Right Side

- ☐ Resident does not require repositioning rails for bed mobility

Therapist: _____