Nursing Unit Changes Indicating Need for Therapy

Resident: _____ Date: _____

A change in any of the areas below on any shift can indicate a reason to screen or evaluate for therapy services. Change must be documented in medical chart. Please refer to therapy.

____ mobility in bed

____ getting on / off bed

____ getting on / off chair

____ wheelchair mobility in room

____ wheelchair mobility in corridor

____ ambulation in room

____ ambulation in corridor

____ stability

____ use of assistive device

____ more assist in am or pm

____ complaint of shortness of breath

____ change in breathing pattern

____ Tires quicker

____ positioning / slouching in chair

____ fall has occurred

____ complaint of pain

____ skin condition changes

____ toileting

____ hygiene

____ feeding

____ dressing

____ bathing

____ swelling in arm / leg

____ swallowing

____ coughing at meals

____ eating less of meal

____ pocketing food

____ dropping food

____ difficulty with meals

____speech clarity

____ weight loss

____ change in cognition

____ incontinence

____ visual changes

____ decreased ROM/possible new onset of joint contracture

PLEASE PLACE THIS FORM IN THE THERAPY MAILBOX ONCE COMPLETED
THANK YOU!

3/2020