

FRACTURED HIP PATIENT / CLIENT INFORMATION CHECKLIST

GREY BRUCE HEALTH NETWORK

Name:	Facility From:	N/A <input type="checkbox"/>
Next of Kin:	Telephone #:	
Key Contact:	Telephone #:	

Admission to Hospital
 Discharge from Hospital
 Med list attached

CATEGORY	SPECIFICATIONS	
PRIOR MOBILITY STATUS	<input type="checkbox"/> Independent	
	<input type="checkbox"/> Wheelchair dependent	
	<input type="checkbox"/> Walker <input type="checkbox"/> Wheeled <input type="checkbox"/> Standard	
	<input type="checkbox"/> Supervised	
TRANSFERS	<input type="checkbox"/> Independent <input type="checkbox"/> One Person <input type="checkbox"/> Two Person <input type="checkbox"/> Partial Weight Bearing %: _____ <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Mechanical Lift <input type="checkbox"/> Non-Weight Bearing <input type="checkbox"/> Sit-to-Stand	
	Assessed for: Assessed by: <input type="checkbox"/> Transfer <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Other: _____ <input type="checkbox"/> Mobility <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Other: _____ <input type="checkbox"/> Exercises <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Other: _____	
	COGNITIVE STATUS	<input type="checkbox"/> Orientation - Time/Place/Person
		<input type="checkbox"/> Sundowner (<i>Agitated/Confused in evening</i>)
<input type="checkbox"/> Able to Follow Instructions		
<input type="checkbox"/> Wanderer		
SKIN INTEGRITY	<input type="checkbox"/> Open Wound/Incision	
	<input type="checkbox"/> At Risk (<i>identify area</i>):	
TOILETING ROUTINE	<input type="checkbox"/> Independent	
	<input type="checkbox"/> Commode	
	<input type="checkbox"/> Uses Products	
	<input type="checkbox"/> Equipment Needed (<i>specify</i>):	
COMMUNICATION BARRIERS	<input type="checkbox"/> Yes (<i>specify</i>):	
	<input type="checkbox"/> No	
SAFETY ISSUES	<input type="checkbox"/> Restraints	
	<input type="checkbox"/> Safety Belts	
	<input type="checkbox"/> Feeding/Swallowing (<i>specify</i>):	
	<input type="checkbox"/> Needs Supervision	
	<input type="checkbox"/> Visual Defects (<i>specify</i>):	
	<input type="checkbox"/> Hearing Defects (<i>specify</i>):	

Special Considerations / Other Factors: _____

Signature: _____ Date: _____

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