GREY BRUCE HEALTH NETWORK

FRACTURED HIP PATIENT / CLIENT INFORMATION CHECKLIST

Name:	Facility From:	N/A ❑
Next of Kin:	Telephone #:	
Key Contact:	Telephone #:	
Admission to Hospital ❑	**Discharge from Hospital ❑**	**Med list attached ❑**

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

Special Considerations / Other Factors: ______________________________

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Signature: ______________________ Date: ______________________

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