



PATIENT HANDLING ASSESSMENT

Name of patient; _____
 Date of birth; _____
 Weight; _____
 Relevant Information Relating to Mobility; _____

History of falls; Yes No If Yes complete Falls Assessment
 Comprehension; _____
 Behaviour; _____

If the patient presents a high risk please note in the comments column. Please refer to Manual Handling Guidelines for all manoeuvres

Date	Lying » sitting	Sit » stand	Stand » sit	Walking	Bathing	Moving up the bed	Turning / proning	Lateral transfers	Floor / bed or cot	Comments	Signed

A risk assessment should be carried out prior to every handling manoeuvre. Any changes should be documented.

MOBILITY CODES

AST 1/2/3; requires assistance of 1/2/3 or more staff
SUP; supervision only
IND; independent
BR; bed rest
NWB; non weight bearing
PWB; partial weight bearing
FWB; full weight bearing

AIDS/ EQUIPMENT CODES

H - hoist (eg mobile / tracking, clip / loop) **BH** – Bathing hoist
ST- En Encore standaid **STA**; eg Oxford standaid
GS; Glidesheet **PAT**; Patslide
HB; Handblocks **Pt T**; Pt turners eg samhalla, Stedy
S; Stick (s) **EC** – elbow crutches
Z; Zimmer **AC**; crutches
W; wheelchair **P**; pushchair

Additional patient assessment

Additional assessment by; _____

Areas of concern	Risk factors	Risk management	Date