PATIENT DETAILS:

PATIENT'S NAME		NHS NUMBER	
D.O.B.		GENDER	
Location (ward/home etc.)	.		

SECTION A

Is the patient fully independent?	**Yes**	**No**

Weight (enter known or estimate) bariatric / plus size patient:	**Weight (Kg)**	**Body size: Small**	**Body size: Medium**	**Body size: Large**
Falls Risk (refer to completed falls Risk Assessment)	**State Low/Medium or High**			
Bed Type (Double, Single, Height Adjustable etc.				
Please briefly state the main considerations or issue affecting manual handling assistance of the patient				

PATIENT DETAILS:

PATIENT'S NAME		NHS NUMBER	
D.O.B.		GENDER	
Location (ward/home etc.)	.		

SECTION B: PLAN			
Activity	**Specific Equipment Used**	**How to Assist (Method)**	**Number of staff**
Into and out of bed			
Turning in bed			
Repositioning in the bed			
Sitting in bed			
Walking			
Chair to chair			
Standing and sitting			
Walking			
Stairs			
Personal hygiene including toilet			
Bathing			

PATIENT DETAILS:

PATIENT'S NAME		NHS NUMBER	
D.O.B.		GENDER	
Location (ward/home etc.)	.		

Other			

SECTION C

Are additional control measures required?	Yes		No	

If yes, give details of additional control measures and inform your manager.

Manager informed?	Yes		No	

Name and Role of Assessor Completing this Form	
Signature	
Date	
Review Date (or if the risk matrix changes)	