MOBILITY SCREENING

Mobility screening is to be completed on all inmates who are identified as having a mobility issue. Identified needs will be met on a temporary basis until evaluated by the clinician in the initial intake physical. The results of this screening will be used in conjunction with the provider assessment to determine permanent measures needed to facilitate participation in major life activities.

Walking/Ambulation			
	Yes	No	N/A
1. Can you walk without assistance?			
Can you walk short distances?			
Is walking difficulty due to breathing problem?			
2. Are you unsteady when walking?			
3. Do you use a cane or walker?			
4. Do you need a wheelchair?			
Can you propel the wheelchair without assistance?			
5. Can you walk up stairs without assistance?			
6. Do you have a prosthesis?			
If so, what extremity?_____ To what level?_____			
Transferring			
7.Can you move from bed to chair or chair to standing without assistance?			
Eating/Nutrition			
8. Can you feed yourself?			
9. Do you need assistance carrying a food tray?			
10. Do you have difficulty chewing and/or swallowing food?			
11. Do you require any adaptive devise to enable you to eat?			
Hygiene/Bathing			
12. Do you need assistance dressing yourself?			
13. Can you put your shoes on and tie them?			
14. Can you shave yourself?			
15. Can you stand in the shower to bathe?			
Do you get weak while standing in the shower?			
16. Do you need assistance bathing?			
17. Can you brush your teeth without assistance?			
Toileting			
18. Are you continent of bladder?			
19. Are you continent of bowel?			
20. Do you need assistance transferring to toilet?			
21. Do you need assistance toileting?			
22. Do you need adult incontinence products?			
23. Do you need assistance changing adult incontinence products?			
24. Do you have a catheter, indwelling or condom type?			
25. Do you self cath?			

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Findings: Inmates found to be in need of devices to assist mobility will be issued temporary passes and devices until seen by provider at initial intake exam.

_____ No indication found for medical assistive devices.

_____Screening indicates need for the following assistive device(s):

Device(s) issued:_____

Date issued: _____ Pass(es) issued: _____

Pass expiration Date: _____

Classification notified of need for impaired inmate assistant: Yes or No Date _____

_____Screening indicates need for assistive device(s), however inmate declines.
See DC4-711A form Affidavit of Refusal.