

Name of Service User: _____		Reference Point: _____																					
ASSESSMENT UNIT			Tick as relevant	Reference Note																			
6. MOBILITY																							
6.1	Physically mobile (not bed-bound)																						
6.2	Permanent or occasional wheelchair use																						
6.3	When moving, service user is physically comfortable and free from pain																						
6.4	Daily routines involve movement between rooms and spaces																						
6.5	Physically capable of standing unaided																						
6.6	No problems with balance or equilibrium																						
6.7	Equilibrium / balance problems - ears checked																						
6.8	Physical support available to help with balance																						
6.9	Physically capable of walking unaided (if aids are required see 6.17)																						
6.10	Negotiates stairs and steps unaided (if aids are required see 6.17)																						
6.11	Transfers to / from a chair unaided and without pain (if aids are required see 6.17)																						
6.12	Transfers to / from a bed unaided and without pain (if aids are required see 6.17)																						
6.13	Capable of washing / showering / bathing unaided and without pain (if aids are required see 6.17)																						
6.14	Uses the toilet unaided and without pain (if aids are required see 6.17)																						
6.15	Uses dance, movement or exercise classes to promote mobility																						
6.16	Effects of medication on mobility																						
6.17	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;">USING A MOBILITY AID OR DEVICE</td> <td style="padding: 5px;">Has the dexterity required to use or operate it</td> <td></td> <td></td> </tr> <tr> <td></td> <td style="padding: 5px;">Has the physical body strength or grip strength required to use or operate it</td> <td></td> <td></td> </tr> <tr> <td></td> <td style="padding: 5px;">Has the fine motor skills required to use or operate it</td> <td></td> <td></td> </tr> <tr> <td></td> <td style="padding: 5px;">Has the touch sensitivity required to use or operate it</td> <td></td> <td></td> </tr> <tr> <td></td> <td style="padding: 5px;">Understands the limitations of the aid or device</td> <td></td> <td></td> </tr> </table>	USING A MOBILITY AID OR DEVICE	Has the dexterity required to use or operate it				Has the physical body strength or grip strength required to use or operate it				Has the fine motor skills required to use or operate it				Has the touch sensitivity required to use or operate it				Understands the limitations of the aid or device				
USING A MOBILITY AID OR DEVICE	Has the dexterity required to use or operate it																						
	Has the physical body strength or grip strength required to use or operate it																						
	Has the fine motor skills required to use or operate it																						
	Has the touch sensitivity required to use or operate it																						
	Understands the limitations of the aid or device																						
Signature of Assessor: _____		Name of Assessor: _____		Date: _____																			