St Vincent's Hospital

Mobile Rehabilitation Team
Occupational Therapy &
Physiotherapy Assessment Handover Sheet

MRN		SURNAME	
OTHER NAMES			
DOB	SEX	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

A

Muscle Strength:
UL: **LL:**

Interventions and Assessments:

Discharge Functional Status:

Transfers:	**Stairs:**
Mobility:	**PADL's:**

Other:

R

Discharge Impairments:

Recommendations:

Date of Discharge from MRT: _____ Patient Contact Number: _____

Discharge Destination _____

Follow Up Outpatients Required: YES / NO Location: _____

Additional Support Services: _____

_____

SIGNATURES: _____

Occupational Therapist - (Page: 6277) Physiotherapist - (Page: 6269)
MRT - Phone: 8382 3316 Fax: 8382 2788

ISBAR - **I -** Introduction **S -** Situation **B -** Background **A -** Assessment **R -** Recommendation

SVH Policy ____

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(Please enter information or affix Patient Information Label)

Hospital Admission: _____ Date started MRT program: _____ DVA ☐

S

Diagnosis

Medical History

Social Situation

Employment/Leisure:

B

Home Environment **OT home visit:** previously performed ☐ required ☐

House Structure: ☐ Single ☐ Double ☐ Unit ☐ Other: _____
House Ownership: ☐ Own ☐ Rented ☐ DOH ☐ Other: _____

Access:

Bathroom:

Toilet:

Chair/Bed:

Equipment Previously Installed

Functional Status

	Previous	Date Admission		Previous	Date Admission
Bed T/F			Stairs		
STS			PADL's		
Mobility			DALD's		
Toilet T/F			Driving		

Cognitive Status MMSE Score: Further Ax Required: Yes ☐ No ☐

Pressure Risk Yes ☐ No ☐ Pressure Cushion In-situ ☐ Required ☐ Air Mattress In-situ ☐ Required ☐

Falls History:

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OCCUPATIONAL THERAPY & PHYSIOTHERAPY ASSESSMENT

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