**BASIC CLIENT MANUAL HANDLING PLAN**

To be used if client is fully or partially weight-bearing and there are no complex medical conditions impacting on manual handling.

**Client Name: DOB: Date of assessment: \_\_/\_\_/\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Weight: |  | Height: |  | Vision: |  | Hearing: |  |
| Sensation: |  | Muscle tone |  | ROM: |  | Balance: |  |
| Speech | Understands | |  | Expresses clearly | |  | |
| Behaviour | Aggressive | |  | Resistive | |  | |
|  | Concentration | |  | Memory |  | Confused |  |
| Medical | Seizures | |  | Continence |  | Delicate Skin |  |
|  | Medications | |  | History of falls |  | Fatigue/ pain |  |

|  |  |  |
| --- | --- | --- |
| **ACTIVITY** | **LEVEL OF ASSISTANCE** | **SPECIFIC COMMENTS/SWMS** |
| Feeding: | Needs full assistance |  |
|  | Needs help with: Cutting food, spreading butter, |  |
|  | Precautions to note |  |
|  | Independent |  |
| Showering: | Needs full assistance: shower trolley, commode chair, standing at rail |  |
|  | Needs help with: reaching feet(lower legs), reaching buttocks, reaching back |  |
|  | Requires supervision |  |
|  | Precautions to note |  |
|  | Independent |  |
| Grooming: | Needs full assistance |  |
|  | Needs help with: shaving, cleaning teeth, hair |  |
|  | Requires supervision with: shaving, cleaning teeth, hair |  |
|  | Precautions to note |  |
|  | Independent |  |
| Dressing: | Needs full assistance: in chair, standing at rail, in bed |  |
|  | Needs help with: top half, bottom half, socks & shoes, buttons, zippers |  |
|  | Requires supervision with: top half, bottom half, socks & shoes, buttons, zippers |  |
|  | Precautions to note |  |
|  | Independent |  |
| Toileting | Incontinent: Pads to be changed on change table with one or two people |  |
|  | Needs assistance with: transfers, clothing adjustment, standing incontinence pad changes |  |
|  | Requires reminders/supervision |  |
|  | Precautions to note |  |
|  | Independent |  |
| Mobility | Non-weight-bearing: electric w/chair, manual w/chair self-propelled, ,manual w/chair – non-self-propelled |  |
|  | Partial weight-bearing: walking frame, walking stick, one person support, leg weakness |  |
|  | Requires supervision |  |
|  | Precautions to note |  |
|  | Fully weight-bearing |  |
| Transfers | Able to sit from lying |  |
|  | Able to sit on side of bed |  |
|  | Able to do a pivot transfer |  |
|  | Standing transfer – one person or rail |  |
|  | Standing transfer – two people |  |
|  | Transfer belt: one person, two people |  |
|  | Slide board |  |
|  | Ceiling or floor hoist  Sling type: |  |
|  | Precautions to note |  |
| Walking | Wheelchair only |  |
|  | Walking frame – no assistance |  |
|  | Walking frame with assistance |  |
|  | Walking stick |  |
|  | Transfer belt: one person, two people |  |
|  | Walking with one or two people |  |
|  | Walk independently up to 10 metres |  |
|  | Walk independently up to 100 metres |  |
|  | Precautions to note |  |
|  | Walk independently |  |
| Stairs | Unable |  |
|  | Able with rail and one person |  |
|  | Able with rail |  |
|  | Limited going up, down |  |
|  | Precautions to note |  |
|  | Independent |  |

Name of person completing assessment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Completed: \_\_/\_\_/\_\_

Date of next review: \_\_/\_\_/\_\_