Departmental Summary of Client Handling Needs

Unit/Department		Date	
Assessment completed by:			
Client Mobility Summary			
Client	**Days**	**Evenings**	**Nights**
Transfers			
Lifts (mechanical)			
Lateral side/transfer			
Repositioning			
Independent			
Other barriers			
Client Handling Equipment and Devices			
Mechanical Lifts		**Assistive Devices**	
Identified Equipment Needs			
Mechanical Lifts		**Assistive Devices**	
Identified Environmental Barriers			
Environmental Barriers		**Recommended Action**	
Identified Organizational Barriers			
Organizational Barriers		**Recommended Action**	