Muscle Strength:
UL: 
LL:

Interventions and Assessments:

Discharge Functional Status:
Transfers: Stairs:
Mobility: PADL's:
Other:

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 _____
St Vincent's Hospital

Mobile Rehabilitation Team
Occupational Therapy & Physiotherapy Assessment

Hospital Admission: ___________ Date started MRT program: ___________ DVA □

Diagnosis

Medical History

Social Situation

Employment/Leisure:

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

<table>
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<th>Previous</th>
<th>Date Admission</th>
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<th>Date Admission</th>
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<tbody>
<tr>
<td>Bed T/F</td>
<td>Stairs</td>
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<td>STS</td>
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<td>Mobility</td>
<td>DALD’s</td>
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<tr>
<td>Toilet T/F</td>
<td>Driving</td>
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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:

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