

**OBJECTIVE ASSESSMENT:**

**Assessment 1**

**Assessment 2**

**Site (department location):**



**Date:**  
(\*Date of first appt)



**Physiotherapist:**



**Height (cm):**



**Weight (kg):**



**Chest expansion (cm):**



**Tragus to Wall (cm):**  
(state right or left)



**Shoulder elevation (deg) right:**



**Shoulder elevation (deg) left:**



**Lumbar endurance (sec):**



**Four test balance scale (sec):**  
(feet together; semi-tandem; tandem; one leg)

1.	/10		
2.	(R) /10	(L) /10	
3.	(R) /10	(L) /10	
4.	(R) /30	(L) /30	

1.	/10		
2.	(R) /10	(L) /10	
3.	(R) /10	(L) /10	
4.	(R) /30	(L) /30	

**30 second chair stand (no ULs, no of reps)**



**Six minute walk:**  
Distance walked (m):



Walking aid used:



**Please note:** number of stops, reason for stopping and any SOB or pain experienced

**Assessment  
Summary:**

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<b>*CODES:</b>	<i>Health problem:</i>	
	<i>Objective:</i>	

**Signed:**

**Print name:**

**Discharge  
Summary:**

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<b>*CODES</b>	<i>Outcome:</i>	
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**Signed:**

**Print name:**

**MANAGEMENT:**

**1. 12 week  
physiotherapy-led,  
exercise classes:**

YES / NO *If not  
offered, why:*

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**Venue:**

*If patient  
declines, why:*

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**2. Pain management:**

YES / NO Details:

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**3. Home exercises:**

YES / NO Details:

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**4. Advice/education:**

YES / NO Details:

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**5. O-Zone referral:**

YES / NO Site:

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**6. Community Falls  
Prevention Programme**

YES / NO Comment:

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**7. Other management:**

YES / NO If Yes, what:

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*Please post a copy of this form to Ann Murray once individual treatment has finished.*