Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

Community Therapy Services

Home Care
Sit-Stand Lift Assessment/Reassessment Form

☐ **Initial** or ☐ **Reassessment**

Date of Assessment: D D M M M Y Y Y Y

Client's Phone Number: ___ - ___ - ____

Client Health Record #
Client Surname
Given Name
Date of Birth
Gender
MFRN
PHIN
Address

Home Visit done: ☐ **Yes** ☐ **No** **Assessment Location:** _____

Client Data: Weight: _____ ☐ pounds ☐ kilograms Height: _____ ☐ feet/inches ☐ centimetres

Reassessment Only

If this is a reassessment, indicate date sit-stand lift was issued: D D M M M Y Y Y Y

☐ WRHA Issued ☐ Client Rental ☐ Client Purchase ☐ Other: _____ Brand/Model: _____

Current Sit-Stand Lift Usage: ☐ For All Transfers ☐ For Seated Transfers Only

Transfer Assistance Provided By: ☐ Home Care Staff ☐ Private Staff ☐ Family/Caregiver ☐ Agency Staff

Assessment Criteria Required For Safe Use of Sit-Stand Lift:

Bed And Seated Transfers: All Criteria Except # 2 Must Be Met
Seated Transfers Only: Criteria 1, 3, 4, 8, 9, 10 Must Be Met

*(Note: If criteria 5, 6, 7 are **not** met, a sit-stand lift is **not** appropriate for bed transfers)*

Minimal Assist Definition: Client must be able to partially assist with transfer. Staff must not lift more than 35 pounds (16 kilograms) of a client's weight when providing physical assistance during any transfer, repositioning task or other aspect of client care.

Assessment Components	**Assessment Outcomes** (Check all that apply)
1. Able to **follow instructions** consistently and reliably	☐ **Yes** ☐ **If Not Able** - Sit-Stand Lift ***is not*** appropriate for transfers
2. Able to **initiate movement of hips/pelvis or raise hips partially off bed** (bridge)	☐ **Independent** ☐ **Assisted With Feet/Ankles Supported** ☐ **Not Able**
3. Able (from seated position) to **extend knee and lift foot at least partially off ground** *or* **quads contraction** palpable when lifting foot	☐ **Right**: Grade 2 or more ☐ **Left**: Grade 2 or more ☐ **Not Able** - Sit-Stand Lift ***not*** appropriate
4. Able to consistently and reliably weight bear **partially on at least one leg for duration of transfer**	☐ **Right** ☐ **Left** ☐ **Not Able**: Sit-Stand Lift ***not*** appropriate
5. Able to **move from lying to sitting *and* able to lift legs off the bed to side of bed**	☐ **Independent** ☐ **Able When Head of Bed Is Raised** **Minimal Assist Needed With:** ☐ Upper body ☐ Lower limbs ☐ **More than Minimal Assist**: Sit-Stand Lift ***not*** appropriate for bed transfers from lying to sitting
6. Able to **move from sitting to lying *and* able to lift legs on the bed**	☐ **Independent** ☐ **Able When Head of Bed Is Raised** **Minimal Assist Needed With:** ☐ Upper body ☐ Lower limbs ☐ **More than Minimal Assist**: Sit-Stand Lift ***not*** appropriate for bed transfers from lying to sitting
7. Able to **maintain balance in sitting on side of bed** independently ***or*** when holding bedrail/pole while sling is applied and removed	☐ **Yes** ☐ **Not Able** - Sit Stand Lift is ***not*** appropriate for transfers in ***or*** out of bed.
8. Able to **sit independently on a seat with arm supports** (wheelchair, commode, chair) ***and*** assist in leaning forward when sling is applied/removed	☐ **Yes** ☐ **Minimal Assist** is required to lean client, but client maintains position independently to apply/remove sling ☐ **More Than Minimal Assistance** required to lean client and/or support in sitting: Sit-Stand Lift ***not*** appropriate
9. Able to **hold handle of Sit-Stand Lift with one or two hands during transfers**. (Moderate or greater grip strength for at least 5 seconds)	☐ **Right** ☐ **Left** ☐ **Both** ☐ **Not Able**: Sit-Stand Lift is ***not*** appropriate for transfers

10. Able to lean back in sling when standing ☐ Yes ☐ No
If client is unable to lean back in sling, is there excessive pressure noted under axillae ☐ Yes ☐ No
If Yes, is weight bearing sufficient? ☐ Yes ☐ No

If No, Sit-Stand is **NOT** appropriate for transfers

If Yes, try the following alternatives and reassess client:
Tighten the belt. Does this relieve pressure? ☐ Yes ☐ No
Try a smaller sling. Does this relieve pressure? ☐ Yes ☐ No
If No, Sit-Stand Lift is **NOT** appropriate for transfers.

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Recommendations Regarding Use of Sit-Stand Lift

☐ **Use of Sit-Stand Lift is Appropriate for *All Transfers*:**

OR

☐ **Use of Sit-Stand Lift is appropriate for *Specific Transfers Only*** (check all that apply):

☐ Bed ☐ Wheelchair ☐ Commode ☐ Other: _____ COMMENTS: _____

All Clients: Reassessment date recommended: |_|_|_|_|_|_|_|_| (M M M Y Y Y Y) Assessment to be done by: _____

Recommendations Regarding Discontinuation of Sit-Stand Lift (Reassessment Only)

☐ **Immediate Discontinuation of Sit-Stand Lift for *Some Transfers:*** (check all that apply)

☐ Bed ☐ Wheelchair ☐ Commode ☐ Other: _____

☐ **Immediate Discontinuation of Sit-Stand Lift for *All Transfers***

Comments: _____

Follow Up

Assessment/Reassessment Findings *Communicated To:* (check all that apply)

☐ Client/Family ☐ Home Care Case Coordinator Name: _____

☐ Home Care Equipment Program Consultant ☐ Primary Therapist ☐ Other: _____

Comments: _____

Based on Assessment/Reassessment *Training* is Required ☐ Yes ☐ No

Training will be completed by: ☐ Assessing Therapist ☐ Primary Therapist ☐ Other: _____

Training will be needed for: ☐ Home Care Staff ☐ Private Staff ☐ Family/Caregivers ☐ Agency Staff

Follow-up for ☐ *Alternate Equipment* or ☐ *Transfer Method* is Required

Follow-up will be completed by: ☐ Assessing Therapist ☐ Primary Therapist ☐ Other: _____

During Reassessment *Mechanical Issues* of the Sit-Stand were Noted ☐ Yes ☐ No

☐ Mechanical integrity and/or safety of lift requires attention (describe): _____

☐ Mechanical issues have been reported to: _____

***Therapy Follow-Up* Required For Non- Sit-Stand Lift Issues Noted During Reassessment** ☐ Yes ☐ No

☐ Occupational Therapy referral recommended regarding: _____

☐ Physiotherapy referral recommended regarding: _____

Ordering Instructions

If ordering a Sit-Stand lift then fax completed form to WRHA Home Care Program Equipment Consultant at 204-940-6620.

Ordering Details Sling Size: _____

Safe Visit Plan in Place: ☐ Yes ☐ No

Details of Safe Visit Plan: _____

Contact Information for Delivery: _____

Occupational Therapist: _____ Phone: |_|_|_|-|_|_|_|-|_|_|_|_| Worksite: _____

Signature: _____ Date: |_|_|_|_|_|_|_|_| (D D M M M Y Y Y Y)