COMMUNITY THERAPY SERVICES INC.
101 – 1601 Buffalo Place Winnipeg, MB R3T 3K7

Addressograph

Transfer Assessment Tool

RELATED DATA						
Res. **follows directions/co-operates:**	Always		Sometimes		Never	
Res. **c/o pain** during transfers:	Always		Sometimes		Never	
Res. **needs help to position equipment:**	Always		Sometimes		Never	

PHYSICAL STATUS						
Resident has use of arms:	Fully		Partially		No	
Resident able to do SLRs:	Fully		Partially		No	
Resident able to bridge:	Fully		Partially		No	

SPECIAL CONSIDERATION RE: USE OF SIT/STAND LIFT										
		1. Does Resident have **adequate weight-bearing** though one/both leg(s)					Yes			No
2. Is Res able to **grip the handles** with 1 or 2 hands?	Yes			No		**3.** Does Res **understand** the transfer method?	Yes			No

FUNCTIONAL CRITERIA	RESIDENT INDEPENDENT	1 ASSIST REQUIRED	2 ASSISTS REQUIRED	RESIDENT NOT ABLE
Able to **sit** on side of bed				
Able to **lift legs** onto mattress				
Able to move from **lying to sitting**				
Able to **lean forward**				
Able to move from **sit to stand**				
Able to **stand with 1 or both feet flat**				
Able to **move feet** and turn				
Able to **walk** with or without aids				
Recommended Lift/Transfer Method	Independent	Stand-by Assist		
	Stand-by Assist	1 Person Assisted Transfer		
		Sit/Stand Lift	2 Person Assisted Transfer	
			Sit/Stand Lift	
			Mechanical Lift	Mechanical Lift

1. Complete the **RELATED DATA** section using check marks as appropriate. (**At least 1 evaluator must have a professional designation)**
2. Complete the **FUNCTIONAL CRITERIA** section using check marks in **all columns that apply**.
3. Using the column with the majority of check marks, **choose the most appropriate method of Lift/Transfer. Also use the RELATED DATA to help determine method.**
4. Place a **check mark** in the box beside the chosen method. Decision making required by two health care workers, with at least one having a licensed professional designation.
5. Post the appropriate **LOGO** in the resident's room and **chart as per procedure.**

Name/Sig. of 2 Evaluators: 1: _____ **2.** _____ **Date:** _____

Comments/Precautions: (Including rationale for choice of transfer, particularly when a previous method is being discontinued.) _____