

Transfer Assessment Tool

Addressograph

RELATED DATA				
Res. follows directions/co-operates:	Always	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>
Res. c/o pain during transfers:	Always	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>
Res. needs help to position equipment:	Always	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>

PHYSICAL STATUS				
Resident has use of arms:	Fully	<input type="checkbox"/>	Partially	<input type="checkbox"/>
Resident able to do SLRs:	Fully	<input type="checkbox"/>	Partially	<input type="checkbox"/>
Resident able to bridge:	Fully	<input type="checkbox"/>	Partially	<input type="checkbox"/>

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

FUNCTIONAL CRITERIA	RESIDENT INDEPENDENT	1 ASSIST REQUIRED	2 ASSISTS REQUIRED	RESIDENT NOT ABLE	
Able to sit on side of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Able to lift legs onto mattress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Able to move from lying to sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Able to lean forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Able to move from sit to stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Able to stand with 1 or both feet flat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Able to move feet and turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Able to walk with or without aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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	

- Complete the **RELATED DATA** section using check marks as appropriate. **(At least 1 evaluator must have a professional designation)**
- Complete the **FUNCTIONAL CRITERIA** section using check marks in **all columns that apply**.
- 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.
- 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.
- 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.) _____