Your Company Name
123 Company Lane
New York, NY 12345
Tel. (123) 456-7890
Fax. (123) 456-7890

NURSING COMMUNICATION FORM

Resident: ______________________________ Date: ____________________

Room:____________________

Resident has been placed on the following Nursing Rehabilitation Program

________________ Nursing ROM ________________ Floor Ambulation Program

________________Orthotics and Prosthetics

Range of Motion

________ Passive Range of Motion ________ Active Range of Motion

________ Both Upper Extremities ________ Both Lower Extremities

________ 5 to 10 repitions each joint BID ________ 5 to 10 repetitions each joint QD

Other: ____

____

Floor Ambulation Program

Device
________ Standard Walker
________ Rolling Walker
________ Straight Cane
________ Narrow Base Quad Cane
________ Wide Base Quad Cane
________ Hemi Walker
________ Axillary Crutches
________ Forearm Crutches
________ Hand Held Assist

Assistance
________ Independent
________ Supervision
________ Minimal Assistance*
________ Moderate Assistance*

Distance in feet:______________________ ________ QD ________ BID

W/C follow by a second person YES NO * X1 ONE PERSON X2 2PEOPLE

Orthotic Device :____

Prosthetic Device:____

Wearing Schedule:____

____

Therapist Signature:____

Nurse's Signature:____

Physician's Signature:____