

RESTORATIVE PROGRAM

TYPE _____

NAME _____ AGE _____ ROOM _____

DATE OF ADMISSION: _____ POSSIBLE D/C PLANS: _____

DIAGNOSIS: _____

ASSESSMENT OF RESTORATIVE NEEDS

Cognition: Alert Confused at times Extremely Confused
 Oriented to: Time Place Persons

	GOOD	FAIR	POOR
Vision			
Hearing			
Memory			
Judgement / Safety Awareness			
Standing Balance			
Sitting Balance			

UE LIMITATIONS: _____

LE LIMITATIONS: _____

Phone: (323) 660-3085 - (800) 750-2012

	SUPERVISED	LIMITED ASSIST	EXTENSIVE ASSIST
Bed Mobility			
Transfers			
Ambulation			
ADL's			

RECOMMENDED TREATMENT ORDER: _____

PROBLEMS / NEEDS	MEASURABLE OBJECTIVE	APPROACHES

SIGNATURE: _____ DATE _____

Name	Room No.	Physician	Med. Rec. No.
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Restorative Nursing Documentation Forms

Lingsheng Yao



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