

RESTORATIVE CARE FLOW RECORD

Month: _____ Year: _____

Rehab Diagnosis: _____ Age: _____

Treatment/Plan and Frequency: _____

Goal(s): _____

Precautions: Falls Seizures Vision Balance Bleeding Other: _____

AMBULATION KEY			RANGE OF MOTION (ROM) KEY	
Type of Assistance	Device(s) Used		Type	Extremity
SB - Standby	GB - Gait belt	HW - Hemi-walker	A - Active	UR - Upper right
0 - Minimum	QC - Quad cane	RW - Roller walker	AA - Active, Assistive	LR - Lower right
1 - Moderate: 1 person	C - Cane	W - Walker	P - Passive	UL - Upper left
2 - Maximum: 2 person	- - -	- - -		LL - Lower left

RESTORATIVE DINING KEY			
Type of Assistance	Device(s) Used		
1 - Needs tray set-up	1 - Glass with lid/tippy cup	8 - Heavy weight utensils	
2 - Verbal prompting/encouragement	2 - Glass with lid and straw	9 - Foam handle utensils	
3 - Needs to be fed by staff	3 - Double handhold on glass/cup	10 - Straw	
4 - Tube feeding	4 - Rubber matting under tray	11 - Nose cup	
5 - Other: _____	5 - Finger foods	12 - Scoop plate	
	6 - Serve in cup/bowl	13 - Other: _____	
	7 - Hand grip utensil holder	14 - Other: _____	

INSTRUCTIONS: Record the appropriate code for each corresponding date to record restorative care provided. As applicable, write in additional types of treatment provided and check the corresponding dates. Code R or H whenever treatment is REFUSED or HELD and record the date and reason for each occurrence on the reverse. The caregiver must record his/her initials for each date that service is provided. Signatures (to identify these initials) and progress notes are recorded on the reverse.

TREATMENT/DATE		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AMBULATION <small>(Use Ambulation Key)</small>	Type																															
	Device(s) used																															
ROM <small>(Use ROM Key)</small>	Type																															
	Extremity																															
RESTORATIVE DINING <small>(Use Restorative Dining Key)</small>	Type																															
	Device(s) used																															
DRESSING <small>(Use Ambulation Assistance Key)</small>	Type																															
	Device(s) used																															
INITIALS																																

NAME—Last First Middle Attending Physician Record No. Room/Bed

Restorative Aide Documentation Sample Form

Raffaella Di Napoli

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