

Electric Lift Chair Assessment

Resident Name: _____ Physician: _____

Pertinent Medical Diagnosis: _____

Has the resident had any previous falls related to use of a lift chair? Yes No

Transfers/Mobility:

Ambulation Status: _____

Transfer Status: _____

Assistive Devices: _____

Lower Extremity Weight Bearing Status: _____

Cognition:

Current BIMs Score: _____

Psychotropic Medication Use that May Impair Cognition/Comprehension: _____

Is the Resident Impulsive (such as getting up without assistance when required)? _____

Lift Chair Use:

Can the resident sit upright, unsupported, and reach outside the base of support? Yes No

Can the resident locate the lift control? Yes No

Can the resident demonstrate safely using the lift control (consider hand dexterity)? Yes No

Once in an "up" position can the resident maintain balance without assistance? Yes No

Once in an "up" position can the resident weight bear on lower extremities to keep themselves from falling or sliding out of the chair? Yes No

Is the resident able to comprehend safe use of the lift chair? Yes No

If the resident has severely impaired cognition (BIMs score 8 or less), is impulsive, had a fall related to the use of the lift chair, or has any "No" answers in the lift chair use section, use of an electric chair should be reconsidered.

Is the resident safely able to use an electric lift chair? Yes No

Signature of Staff Completing Assessment: _____

Date: _____