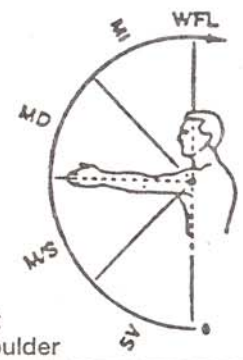
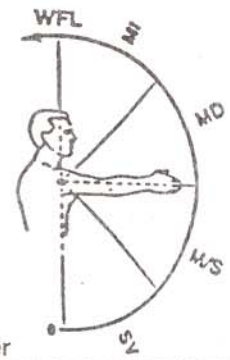
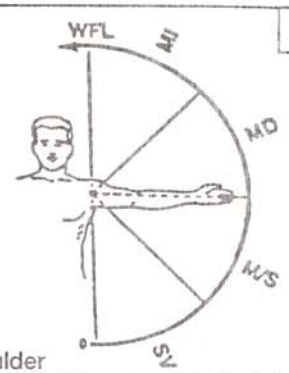
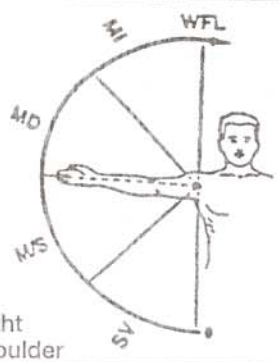
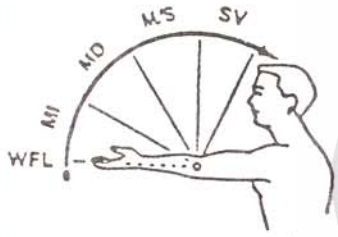
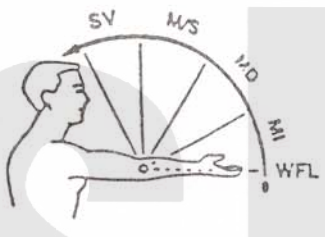
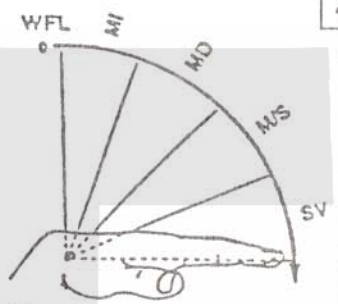
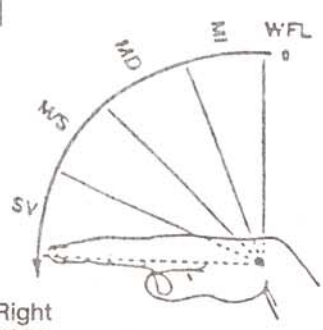
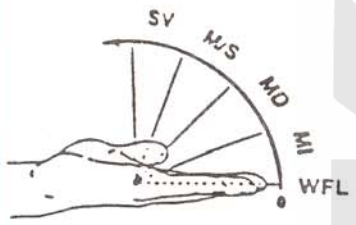
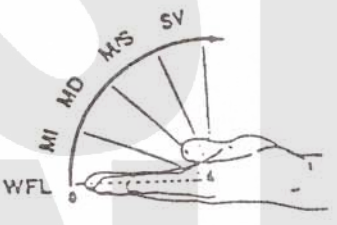
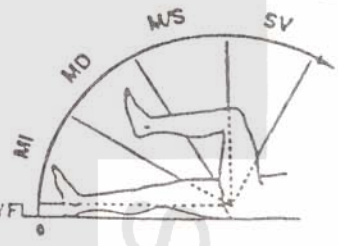
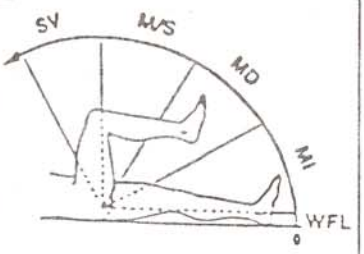
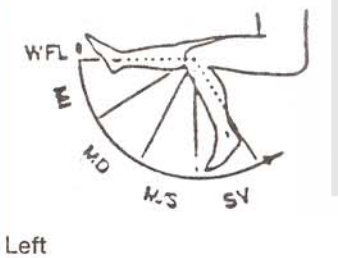
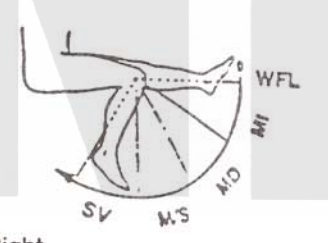
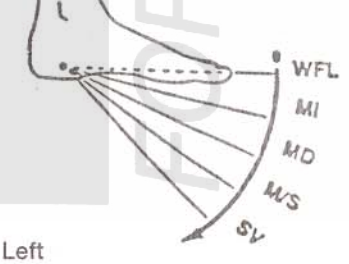
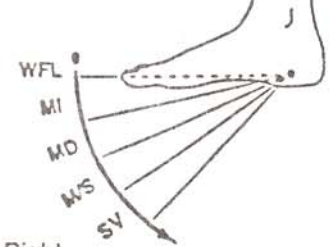
Left	Right	Left	Right
1  Left Shoulder	 Right Shoulder	 Left Shoulder	2  Right Shoulder
3  Left Elbow	 Right Elbow	 Left Wrist	4  Right Wrist
5  Left Hand/Fingers	 Right Hand/Fingers	 Left Hip	6  Right Hip
7  Left Knee	 Right Knee	 Left Ankle	8  Right Ankle

Joint Mobility Limitation (Approximate % available ROM)

Key: MI – Minimal (75 to 100%) MD – Moderate (50 to 75%) M/S – Moderate/Severe (25 to 50%) SV – Severe (0 to 25%) WFL – Variance due to normal aging process allowed

Limitation circled represents approximate limitation.

Check one: ☐ Initial Assessment ☐ Annual Assessment ☐ Change in Condition

Assessor Signature: _____ Date: _____

NAME – LAST	FIRST	MIDDLE	ROOM #	ATTENDING PHYSICIAN	HOSP. #

JOINT MOBILITY ASSESSMENT

JOINT MOBILITY ASSESSMENT

DATE: ______________________ (check one) ☐ **INITIAL ASSESSMENT** ☐ **ANNUAL ASSESSMENT** ☐ **CHANGE IN CONDITION**

Problem Summary ______________________

Effectiveness of Program: ☐ ROM ☐ Splint ☐ Positioning ☐ Improved Joint Mobility ☐ Maintained Assessed Mobility

☐ Deterioration noted in the following joints: ______________________

Resident Tolerance of Program: ☐ Well ☐ Poorly ☐ Refuses

Comments: ______________________

Adjustments to Program: ______________________

Signature of Licensed Nurse: ______________________

NOTE: *Signature of Licensed Nurse indicates that appropriate adjustment to programs have been added to the resident care plan.*

DATE:	**QUARTERLY ASSESSMENT**

Problem Summary ______________________

Effectiveness of Program: ☐ ROM ☐ Splint ☐ Positioning ☐ Improved Joint Mobility ☐ Maintained Assessed Mobility

☐ Deterioration noted in the following joints: ______________________

Resident Tolerance of Program: ☐ Well ☐ Poorly ☐ Refuses

Comments: ______________________

Adjustments to Program: ______________________

Signature of Licensed Nurse: ______________________

NOTE: *Signature of Licensed Nurse indicates that appropriate adjustment to programs have been added to the resident care plan.*

DATE:	**QUARTERLY ASSESSMENT**

Problem Summary ______________________

Effectiveness of Program: ☐ ROM ☐ Splint ☐ Positioning ☐ Improved Joint Mobility ☐ Maintained Assessed Mobility

☐ Deterioration noted in the following joints: ______________________

Resident Tolerance of Program: ☐ Well ☐ Poorly ☐ Refuses

Comments: ______________________

Adjustments to Program: ______________________

Signature of Licensed Nurse: ______________________

NOTE: *Signature of Licensed Nurse indicates that appropriate adjustment to programs have been added to the resident care plan.*

DATE:	**QUARTERLY ASSESSMENT**

Problem Summary ______________________

Effectiveness of Program: ☐ ROM ☐ Splint ☐ Positioning ☐ Improved Joint Mobility ☐ Maintained Assessed Mobility

☐ Deterioration noted in the following joints: ______________________

Resident Tolerance of Program: ☐ Well ☐ Poorly ☐ Refuses

Comments: ______________________

Adjustments to Program: ______________________

Signature of Licensed Nurse: ______________________

NOTE: *Signature of Licensed Nurse indicates that appropriate adjustment to programs have been added to the resident care plan.*

RESIDENT NAME: ______________________ MED. REC. # ____________ PHYSICIAN: ______________________