Date:

2015

MM

DD

Name and NHI

Patient:

Min

Hrs:

Time of mobilisation:

PT Name

Post-operative day 1 assessment completed by:

* **Mobilisation was terminated in sitting**

 *OR*

* **Mobilisation was terminated in standing**

|  |
| --- |
| If mobilisation was terminated due to the patient experiencing symptom(s) of orthostatic intolerance, which of the following symptom(s) did the patient develop? Please tick all that apply |
| * Intolerable Dizziness
 | * **Feeling of heat**
 |
| * Nausea
 | * **Syncope (i.e. vasovagal/fainting)**
 |
| * Vomiting
 | * **Other**
 |
| * Blurred Vision
 |  |
| 2. Highest verbally rated pain during mobilisation on a scale 0-10 (where 0=no pain and 10=worst pain imaginable ):  No Yes 3. Was the patient mobilised out of bed on the day of surgery? Comments: |
|  |
|  |
|  |