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: | |
|  | |
|  | |
|  | |