Pre-Assessment Form for Night-Time Positioning Equipment

Client Details			
Client Name:			
Date of Birth:	/ /	Weight:	
Date of Assessment:	/ /	Caregiver Name:	
Gender (circle):	M / F	Contact:	
Reason for referral:			
Main goals to be achieved:			

Medical History					
Diagnosis:		Condition:	☐ Stable	☐ Deteriorating	
Sensation:	☐ Intact	☐ Impaired			
Sleep History: (quality/number of awakes)					
Pain History: (areas of concern)					
Pressure Injuries: (areas of concern)					
Incontinence Issues?	☐ Yes	☐ No	Thermoregulation Issues?	☐ Yes	☐ No
Seizure Activity?	☐ Yes	☐ No			
Breathing Issues?	☐ Yes	☐ No	Risk of Aspiration?	☐ Yes	☐ No
How does the client transfer on and off the bed?	☐ Independant	☐ Caregivers			
Does the client change their position in bed?	☐ Yes	☐ No			
Are they repositioned over night?	☐ Yes	☐ No	How many times a night?		
What is the main reason for changing their position?					

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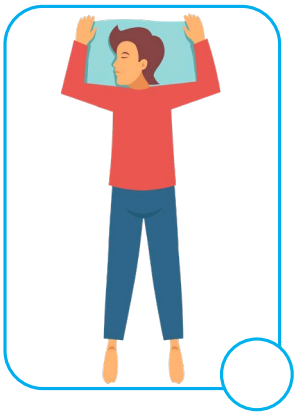
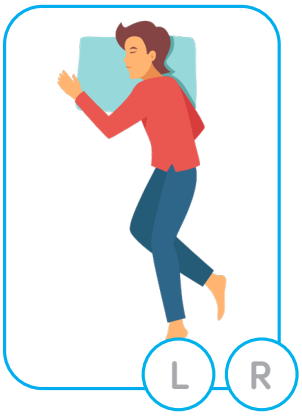
Personal & Enviromental Factors			
What size bed does the client use?	☐ Cot	☐ Single	☐ Double
	☐ Queen	☐ Co-sleeping	☐ Other
What type of mattress does the client have?	☐ Air	☐ Foam	☐ Other
Do they currently use any support while in bed?	☐ No	☐ Yes	If yes, please describe:
Preferred/ habitual posture for lying?	☐ Prone	☐ Side-lying	☐ Semi side-lying ☐ Supine

Which of the next images reflect their habitual position to lie in bed, without support (select option):

Prone



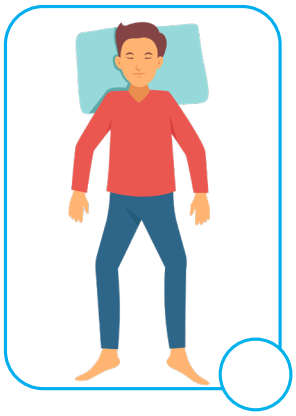
Side-Lying, Extended



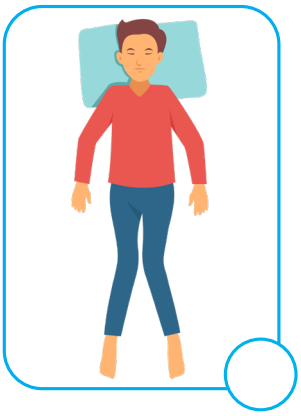
Side-Lying, Flexed

Supine (Windswept Hips)

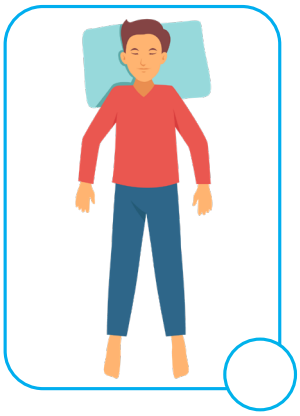
Supine (Abducted Hips)



Supine (Adducted Hips)



Supine



If other, please describe:			
Is supine lying possible and tolerable?	☐ Yes ☐ No	If so, does the pelvis rotate sideways when both knees are flexed and in midline?	☐ Yes ☐ No

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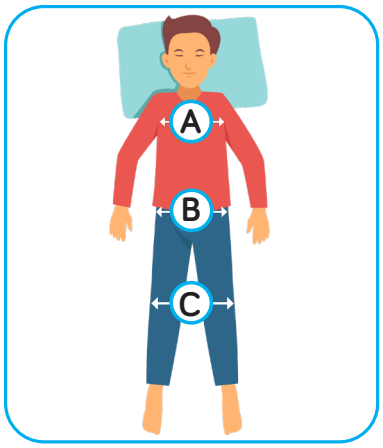
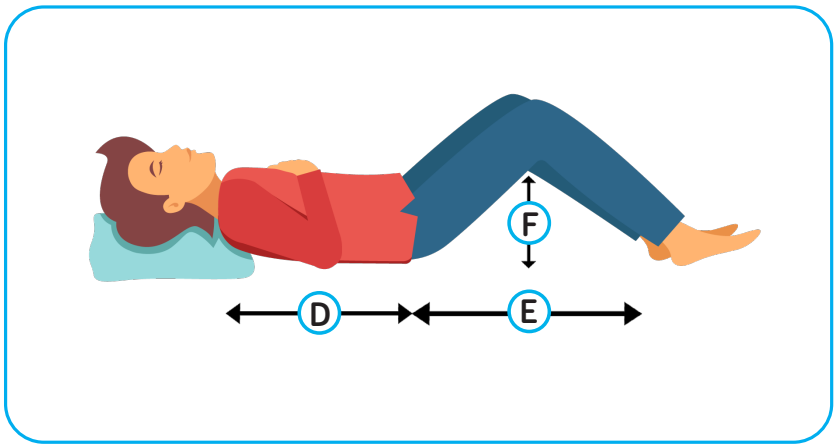
Approximate measurements of the client (taken in supine if possible)			
(A) - Chest width:	cm	(D) - Trunk height:	cm
(B) - Hip width:	cm	(E) - Hip-to-ankle:	cm
(C) - Knee-to-knee width:	cm	(F) - Knee-to-surface:	cm





Main postural issues to be addressed with the product:	
Possible barriers that may impact the success of the intervention:	
Main product parameters and possible trial equipment:	
Is there any specific items you would like to see during the trial?	

Additional Notes

Therapist Details			
Name:		Contact Number:	
Company:		Email Address:	

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