

## CLINICAL INFORMATION: Standing & Walking Mobility

CI-Standing and Walking Mobility-10MWT-MULT

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### 10 Meter Walk Test

	ADMISSION (Within 7 days)	THRESHOLD (Within 2 days of meeting criterion*)	DISCHARGE (Within 7 days)
<b>Date:</b> (If completed over multiple sessions, enter date of completion)	YYYY-MM-DD	YYYY-MM-DD	YYYY-MM-DD
<b>Therapist Name/Initials:</b>			
<b>Did patient meet threshold criterion at time of assessment?</b> <i>*Functional Walking Capacity:</i>  3B)Independent Household Ambulator: ability to ambulate daily using reciprocal steps over ground for short distances (10-100m) independently for functional walking.  <b>**Note: if patient doesn't meet threshold criterion at admission, please monitor and perform threshold test if function changes</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No; If No, enter current gait status: _____ (e.g., ambulates with min. assist and walking belt)	<i>Only performed if patient does not meet threshold criterion at admission but function improves to meet threshold criterion at some time during their inpatient stay.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If No, enter current gait status: _____ (e.g., ambulates with min. assist and walking belt)
<b>If patient met threshold criterion, but test not performed, specify reason:</b>	Reason:	Reason:	Reason:
<b>Number of Sessions for Test Completion:</b> <i>Note: Test can be completed over multiple sessions during the time period indicated if required.</i>			

### 10 Meter Walk Test

10 Meter Walk Test		ADMISSION (Within 7 days) <b>OR</b> THRESHOLD (Within 2 days of meeting criterion*) (Circle which test was done)		DISCHARGE (Within 7 days)	
1.	<b>10 Meter Walk Test (10MWT) at preferred speed:</b>	Time:____(sec)	Speed:____(m/sec)	Time:____(sec)	Speed:____(m/sec)
2.	<b>10 Meter Walk Test (10MWT) at maximum speed:</b>	Time:____(sec)	Speed:____(m/sec)	Time:____(sec)	Speed:____(m/sec)
3.	<b>Walking Aid Used:</b> (and circle right/left/both if applicable to indicate the side on which the aid is used)	<input type="checkbox"/> None <input type="checkbox"/> Parallel bars <input type="checkbox"/> Standard walker <input type="checkbox"/> 2 wheeled walker <input type="checkbox"/> 4 wheeled walker <input type="checkbox"/> Crutches – Right / Left / Both <input type="checkbox"/> Quad cane <input type="checkbox"/> Standard cane – Right / Left / Both <input type="checkbox"/> Knee Ankle Foot Orthosis (KAFO) – Right/Left (if required bilaterally, patient does not meet threshold criteria for test) <input type="checkbox"/> Ankle Foot Orthosis - Right / Left / Both <input type="checkbox"/> Other Aid (specify): _____		<input type="checkbox"/> None <input type="checkbox"/> Parallel bars <input type="checkbox"/> Standard walker <input type="checkbox"/> 2 wheeled walker <input type="checkbox"/> 4 wheeled walker <input type="checkbox"/> Crutches – Right / Left / Both <input type="checkbox"/> Quad cane <input type="checkbox"/> Standard cane – Right / Left / Both <input type="checkbox"/> Knee Ankle Foot Orthosis (KAFO) – Right/Left (if required bilaterally, patient does not meet threshold criteria for test) <input type="checkbox"/> Ankle Foot Orthosis - Right / Left / Both <input type="checkbox"/> Other Aid (specify): _____	

#### Data Collection Details (for RHSCIR study use only)

<b>Collected by:</b> (please print name)		<b>Initial Here:</b>		<b>Date Abstraction Completed:</b>	YYYY-MM-DD
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