



# CYCLE Participant

ID#:	Name:	Room #:	Age:	Sex: M F
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Name of Therapist:

Date:

Name of Assessor:

Date:

<p>Dx:</p> <p>Equipment for Mobility:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Abdominal Binder</li> <li><input type="checkbox"/> Rollator Walker</li> <li><input type="checkbox"/> Standard Walker</li> <li><input type="checkbox"/> 2 Wheeled Walker</li> <li><input type="checkbox"/> Cane</li> <li><input type="checkbox"/> Crutches</li> <li><input type="checkbox"/> Other:</li> </ul> <p>Weight bearing or other orthopedic restrictions:</p> <p>Other Info:</p>	<p>In terms of mobility this person is:</p> <p style="text-align: center;">Indep      Sup      Assistx1      Assistx2</p> <p>Current Mobility:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> To edge of bed</li> <li><input type="checkbox"/> To chair</li> <li><input type="checkbox"/> Marching on spot</li> <li><input type="checkbox"/> Ambulating _____ m with _____ aid</li> <li><input type="checkbox"/> Stairs _____</li> </ul> <p>Other components of the patients' current treatment that should be completed on Ax day:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Resp Ax and Rx</li> <li><input type="checkbox"/> Bed/chair exercises: _____</li> <li>_____</li> <li>_____</li> <li><input type="checkbox"/> Other: _____</li> <li>_____</li> <li>_____</li> </ul>
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### Update for Therapist:

What components of the Ax did the patient complete?

Additional Notes:

- MMT
- PFIT – Sit to Stand
- PFIT- Marching on the Spot
- 30 Second Sit-to-stand
- 2MWT
- None

### Contacts

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