

# Elderly Mobility Scale Assessment Form

## PATIENT DEMOGRAPHICS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ dd / mm / yyyy

Date of Assessment: \_\_\_\_\_ dd / mm / yyyy Practitioner: \_\_\_\_\_

Assistive devices or mobility aids currently in use

## MOBILITY ASSESSMENT

1. Lying to sitting

0 1 2 3

2. Sitting to lying

0 1 2 3

3. Sitting to standing

0 1 2 3

4. Standing

0 1 2 3

5. Gait

0 1 2 3

6. Timed walk (6 metres)

0 1 2 3

7. Functional reach

0 1 2 3

## SCORING AND INTERPRETATION

Total Score: \_\_\_\_\_

Clinical Interpretation

Recommendations

Clinician Signature

Date: \_\_\_\_\_ dd / mm / yyyy