RESTORATIVE CARE FLOW RECORD

Month: ____________ Year: ______

Rehab Diagnosis: ____________________ Age: ______

Treatment Plan and Frequency: ____________________

Goal(s): ____________________

Precautions: ❑ Falls ❑ Seizures ❑ Vision ❑ Balance ❑ Bleeding ❑ Other: ____________

AMBULATION KEY			RANGE OF MOTION (ROM) KEY	
Type of Assistance	**Device(s) Used**		**Type**	**Extremity**
SB - Standby	**GB** - Gait belt	**HW** - Hemi-walker	**A** - Active	**UR** - Upper right
0 - Minimum	**QC** - Quad cane	**RW** - Roller walker	**AA** - Active, Assistive	**LR** - Lower right
1 - Moderate: 1 person	**C** - Cane	**W** - Walker	**P** - Passive	**UL** - Upper left
2 - Maximum: 2 person	___ - ____________	___ - ____________		**LL** - Lower left

RESTORATIVE DINING KEY		
Type of Assistance	**Device(s) Used**	
1 - Needs tray set-up	**1** - Glass with lid/sippy cup	**8** - Heavy weight utensils
2 - Verbal prompting/encouragement	**2** - Glass with lid and straw	**9** - Foam handle utensils
3 - Needs to be fed by staff	**3** - Double handhold on glass/cup	**10** - Straw
4 - Tube feeding	**4** - Rubber matting under tray	**11** - Nose cup
5 - Other: ____________	**5** - Finger foods	**12** - Scoop plate
	6 - Serve in cup/bowl	**13** - Other: ____________
	7 - Hand wrap utensil holder	**14** - Other: ____________

INSTRUCTIONS: Record the appropriate code for each corresponding date to record restorative care provided. As applicable, write in additional types of treatment provided and check the corresponding dates. Code **R** or **H** whenever treatment is **REFUSED** or **HELD** and record the date and reason for each occurrence on the reverse. The caregiver must record his/her initials for each date that service is provided. Signatures (to identify these initials) and progress notes are recorded on the reverse.

▼TREATMENT/DATE▶		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AMBULATION (Use Ambulation Key)	Type																															
	Device(s) used																															
	Distance walked (in feet)																															
ROM (Use ROM Key)	Type																															
	Extremity																															
RESTORATIVE DINING (Use Restorative Dining Key)	Type																															
	Device(s) used																															
DRESSING (Use Ambulation Assistance Key)	Type																															
	Device(s) used																															
INITIALS ▶																																

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

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RESTORATIVE CARE PROGRESS NOTES

All notes must be signed with name and title.

DATE	PROGRESS NOTES	DATE	PROGRESS NOTES

INITIALS	SIGNATURE/TITLE	INITIALS	SIGNATURE/TITLE

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

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