

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 grip 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																															
ROM (See 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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JG Myers



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