

Brighton Mobility Score/20

Functional mobility from bed bound to fully mobile

0



Bed bound: all personal care in bed; needs feeding, turning and full assistance

Date:

1



Bed bound: can manage some hydration/nutrition in bed; no safe sitting balance

Date:

2



Hoisted bed to chair; sitting balance tolerated for < 2 hours

Date:

3



Hoisted bed to chair; sitting balance tolerated for > 2 hours

Date:

4



Sara Stedy/equivalent transfer bed to chair; sitting tolerance < 2 hours

Date:

5



Sara Stedy/equivalent transfer bed to chair; sitting tolerance > 2 hours

Date:

6



Standing transfer bed/chair with frame or aid + 2 people

Date:

7



Standing transfer bed/chair with frame or aid + 1 person

Date:

8



Standing transfer with frame/aid with supervision only

Date:

9



Standing transfer with frame/aid independently

Date:

10



Can stand with frame independently

Date:

11



Can walk with frame + 2 people for < 5 m

Date:

12



Can walk with frame + 1 person for < 5 m

Date:

13



Can walk with frame + 1 person for 5-10 m

Date:

14



Can walk with frame independently for < 5 m

Date:

15



Can walk with frame independently for 5-10 m

Date:

16



Can walk with frame independently for > 10 m

Date:

17



Can walk with stick for 5-10 m

Date:

18



Can walk with stick for > 10 m

Date:

19



Can walk unaided for 5-10 m

Date:

20



Fully mobile: walks unaided > 10 m, independent transfers and basic mobility

Date:



Use the highest level the patient can safely achieve most of the time.
This scale is for functional mobility only and does not include cognitive or medical status.

Social History & Package of Care

1 Home / Residence



House

☐


Bungalow

☐


Flat / Apartment

☐


Sheltered Housing

☐


Residential Home

☐


Nursing Home

☐

2 Living Situation



Lives alone

☐


Lives with partner

☐


Lives with family

☐


Lives with carer

☐


Other _____

☐

3 Access



Ground floor

☐


Floor number



Lift:

☐ Yes

☐ No



Steps to enter



Indoor stairs:

☐ Yes

☐ No



Handrail:

☐ Yes

☐ No

4 Mobility Aids at Home



None

☐


Stick

☐


Frame

☐


Rollator

☐


Wheelchair

☐


Powered chair / scooter

☐


Hospital bed

☐


Other

☐

5 Package of Care (POC)

Care Visits / Day Cycle



Morning

☐


Lunch

☐


Tea

☐


Evening

☐


Night

☐

Number of visits per day _____

Days per week _____

Care agency _____

Informal support from family/friends _____

What the package of care helps with (tick all that apply)



Washing

☐


Dressing

☐


Toileting

☐


Transfers

☐


Meals

☐


Medication

☐


Shopping

☐


Housework

☐

6 Baseline Function / Social Notes

7 Point of Contact / Key Contact

Key Contact

Name _____

Relationship _____

Telephone _____

Completed by _____

Date _____