REFUSAL TO PERFORM PATIENT MOBILITY ASSESSMENT FORM

It is the right of each employee to refuse to move a patient, but there must be a clear and objective reason for the refusal. If patient mobility assistance is part of an employee’s job description, and the employee refuses to perform this job function, meet with the employee each time and document their reasons for the refusal. This form should be signed by both employee and manager, and placed in the employee’s personnel file.

EMPLOYEE NAME: ___________________________  UNIT: ___________  DATE: _____________
PATIENT: ______________________________________________________  MRN: ____________

☐ Assistance from other personnel was not available. Describe attempts made to locate other personnel: _____________________________________________________________

☐ Lifting equipment was not available; describe: ________________________________

☐ Lifting restrictions; physician documentation verified ☐ Yes ☐ Not on file

☐ Patient impulsive or combative

☐ Lack of training in proper lifting techniques

☐ Faulty or broken equipment; describe: ___________________________________________

☐ Other: ___________________________________________________________________

___________________________________________________________________________

Signed: _________________________________  Date: ____________________________
Employee

Signed: _________________________________  Date: ____________________________
Manager / Supervisor