



CLINICAL INFORMATION: Standing & Walking Mobility

CI-Standing and Walking Mobility-10MWT-MULT

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10 Meter Walk Test

	ADMISSION (Within 7 days)	THRESHOLD (Within 2 days of meeting criterion*)	DISCHARGE (Within 7 days)
Date: (If completed over multiple sessions, enter date of completion)	YYYY-MM-DD	YYYY-MM-DD	YYYY-MM-DD
Therapist Name/Initials:			
Did patient meet threshold criterion at time of assessment? <i>*Functional Walking Capacity:</i> 3B) Independent Household Ambulator: ability to ambulate daily using reciprocal steps over ground for short distances (10-100m) independently for functional walking. **Note: if patient doesn't meet threshold criterion at admission, please monitor and perform threshold test if function changes	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, enter current gait status:</i> _____ _____ (e.g., ambulates with min. assist and walking belt)	<i>Only performed if patient does not meet threshold criterion at admission but function improves to meet threshold criterion at some time during their inpatient stay.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, enter current gait status:</i> _____ _____ (e.g., ambulates with min. assist and walking belt)
If patient met threshold criterion, but test not performed, specify reason:	Reason: _____	Reason: _____	Reason: _____
Number of Sessions for Test Completion: <i>Note: Test can be completed over multiple sessions during the time period indicated if required.</i>			

10 Meter Walk Test

10 Meter Walk Test		ADMISSION (Within 7 days) OR THRESHOLD (Within 2 days of meeting criterion*) (Circle which test was done)		DISCHARGE (Within 7 days)	
1.	10 Meter Walk Test (10MWT) at preferred speed:	Time: _____ (sec)	Speed: _____ (m/sec)	Time: _____ (sec)	Speed: _____ (m/sec)
2.	10 Meter Walk Test (10MWT) at maximum speed:	Time: _____ (sec)	Speed: _____ (m/sec)	Time: _____ (sec)	Speed: _____ (m/sec)
3.	Walking Aid Used: <i>(and circle right/left/both if applicable to indicate the side on which the aid is used)</i>	<input type="checkbox"/> None <input type="checkbox"/> Parallel bars <input type="checkbox"/> Standard walker <input type="checkbox"/> 2 wheeled walker <input type="checkbox"/> 4 wheeled walker <input type="checkbox"/> Crutches – Right / Left / Both <input type="checkbox"/> Quad cane <input type="checkbox"/> Standard cane – Right / Left / Both <input type="checkbox"/> Knee Ankle Foot Orthosis (KAFO) – Right/Left (if required bilaterally, patient does not meet threshold criteria for test) <input type="checkbox"/> Ankle Foot Orthosis – Right / Left / Both <input type="checkbox"/> Other Aid (specify): _____		<input type="checkbox"/> None <input type="checkbox"/> Parallel bars <input type="checkbox"/> Standard walker <input type="checkbox"/> 2 wheeled walker <input type="checkbox"/> 4 wheeled walker <input type="checkbox"/> Crutches – Right / Left / Both <input type="checkbox"/> Quad cane <input type="checkbox"/> Standard cane – Right / Left / Both <input type="checkbox"/> Knee Ankle Foot Orthosis (KAFO) – Right/Left (if required bilaterally, patient does not meet threshold criteria for test) <input type="checkbox"/> Ankle Foot Orthosis – Right / Left / Both <input type="checkbox"/> Other Aid (specify): _____	

Data Collection Details (for RHSCIR study use only)

Collected by: (please print name)		Initial Here:		Date Abstraction Completed:	YYYY-MM-DD
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