

Name: _____ DOB: _____

Standing Order for Safety Devices/Interventions

Please circle all that apply

Please circle all that apply that is necessary to meet functional and/or medical needs in the least restrictive manner possible.

Cane Walker Gait Belt Gait Walker

Wheelchair Wheelchair w/ Seat Belt Wheelchair w/ Safety Harness

Wheelchair Safety Brakes Hoyer Lift Helmet

(Wheelchair has been assessed/evaluated and meets the current needs of this individual.)

Hospital Bed Bed Rails (full or half) Bed Alarm Fall Mat

Shower Chair/Bench Bedside Commode Raised Toilet Seat

Gloves (to prevent damage from skin picking) Compression Socks

Other (Specify): _____

Physician Printed Name: _____

Signature: _____

Date: _____