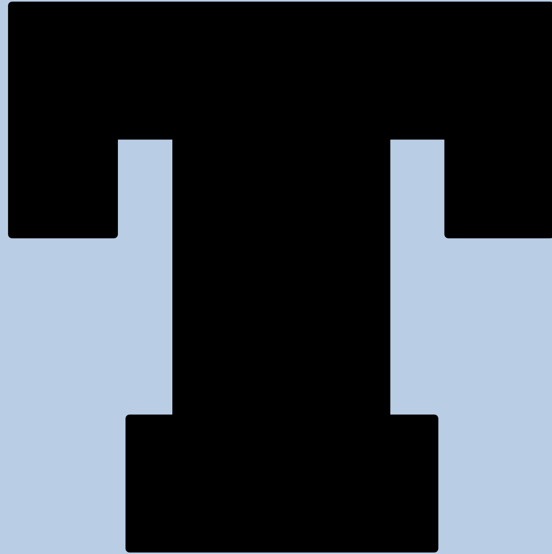
Patient Name: ______________________________ Date: ___________ Name: ______________

Therapeutic Falls



Activities

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Temporary Pause of Therapeutic Falls

S

- ❑ Requires SUPERVISION for mobility
- ❑ Therapists will re-assess
- ❑ ______________________________

Supervision = Stay within arm's length to be able to help