Norton Scale for Assessing Risk of Pressure Ulcers*

Criterion Score Physical condition 4 = Good 3 = Fair 2 = Poor 1 = Very bad Mental condition 4 = Alert 3 = Apathetic 2 = Confused 1 = Stupor Activity 4 = Ambulant 3 = Walk with help 2 = Chair bound 1 = Bed bound Mobility 4 = Full 3 = Slightly impaired 2 = Very limited 1 = Immobile Incontinent 4 = Not 3 = Occasionally 2 = Usually/Urine 1 = Doubly	Date:
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3 = Slightly impaired 2 = Very limited 1 = Immobile Incontinent 4 = Not 3 = Occasionally 2 = Usually/Urine	1 = Bed bound
2 = Very limited 1 = Immobile Incontinent 4 = Not 3 = Occasionally 2 = Usually/Urine	4 = Full
1 = Immobile Incontinent 4 = Not 3 = Occasionally 2 = Usually/Urine	3 = Slightly impaired
Incontinent 4 = Not 3 = Occasionally 2 = Usually/Urine	2 = Very limited
3 = Occasionally 2 = Usually/Urine	1 = Immobile
2 = Usually/Urine	4 = Not
	3 = Occasionally
1 = Doubly	2 = Usually/Urine
	1 = Doubly
TOTAL SCORE =	

Source: Doreen Norton, Rhoda McLaren and A N Exton-Smith, An Investigation of Geriatric Nursing Problems in Hospital, © National Corporation for the Care of Old People (now Centre for Policy on Ageing), London, 1962.

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^{*}Calculated as the sum of the scores in all 5 areas. A score < 14 indicates a high risk of pressure ulcer development.