**SAFETY ASSESSMENT**

Visit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Is the patient still driving? 🗖 YES 🗖 NO**

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| For the patient: | * How have your driving behaviors/in-traffic skills changed?
* Have you had any traffic accidents?
* Have you considered making a plan for when you are no longer able to drive?
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| For the family/caregiver: | * Is the patient a good driver?
* Has the patient been involved in any recent accidents, including fender benders, or been issued any tickets?
* Do you have any concerns about a passenger riding with the patient?
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1. **Is the patient taking medications as prescribed? 🗖 YES 🗖 NO**

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| For the patient: | * It’s not uncommon for older adults to sometimes forget to take their medications. Does that ever happen to you?
* What do you do to help you remember to take your medications?
* How do you tell your medications apart? Do you use pill boxes?
* Who fills your pill boxes? How do you refill your prescriptions?
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| For the family/caregiver: | * How is the patient doing with his or her medications?
* How confident are you that he or she is taking them as directed?
* Do you ever notice that there are too many or not enough pills at the end of the month?
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1. **Are there concerns about safety in the home? 🗖 YES 🗖 NO**

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| For the patient: | * Have you had any safety-related incidents at home?
* Do you feel safe in your home?
* Do you use the stove to cook?
* Is it becoming more difficult for you to complete chores?
* Do you ever smoke while alone in your home?
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| For the family/caregiver: | * Do you feel comfortable leaving the person home alone?
* Have you noticed any burned pans or other signs of issues with the stove or other appliances?
* Do you have any concerns about the person’s cooking or eating habits?
* Are there working smoke detectors and fire extinguishers in the home?
* Are there any concerns about the patient harming themselves or others?
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1. **Has the patient gotten lost in familiar places or wandered? 🗖 YES 🗖 NO**

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| For the patient: | * Have you ever gotten lost in places that are familiar to you?
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| For the family/caregiver: | * Has the patient ever come home much later than expected without an explanation?
* Does the patient ever try to leave the house or ask to “go home” when he or she is already at home?
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1. **Are firearms present in the home? 🗖 YES 🗖 NO**

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| For the patient: | * Do you have firearms in your home?
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| For the family/caregiver: | * Are there firearms in the home?
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1. **Has the patient experienced unsteadiness or sustained falls? 🗖 YES 🗖 NO**

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| For the patient: | * Do you feel unsteady on your feet?
* Have you fallen recently?
* Are you limiting outings or travel due to fear of falling?
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| For the family/caregiver: | * Does the patient seem unsteady on his or her feet?
* Has the patient fallen recently?
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1. **Does the patient live alone? 🗖 YES 🗖 NO**

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| For the patient: | * Do you live alone?
* Tell me about a good day. What works well for you in your routine and what are your challenges?
* It is not uncommon for older adults to need some assistance to remember their medications, how do you manage that?
* Do you ever feel lonely, isolated or scared?
* Are you having any challenges getting to appointments, visiting friends or running errands?
* Have you noticed any changes in your eating habits?
* Have you had any trouble paying your bills or balancing your checkbook?
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| For the family/caregiver: | * Have you thought about when it will no longer be safe for the patient to live alone?
* Do you have any concerns about the patient’s ability to live alone?
* Are you confident that the patient is eating regularly; getting to appointments; managing finances; able to shop, clean and prepare meals?
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