**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? |
|  |  |
| 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? |
|  |  |
| 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? |
|  |  |
| 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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