HOME SAFETY ASSESSMENT

Patient Name:_____ **DOB:**_____
Address:_____
Evaluation Date:_____

Item No:	Description: Environment	Yes	No	N/A
1	Safe and Adequate food and water supplies			
2	Working Refrigerator			
3	Adequate Heat and Ventilation			
4	Free from Infestation			
5	Pathways free of obstacles such as loose rugs, furniture etc.			
6	If oxygen in use, appropriate signage			
7	Clean Area exists to store medical supplies			
8	Emergency numbers available			
9	Running water and functioning toilet in home			
	Fire /Electrical			
1	Electricity is on in the home			
2	Working Smoke Detector in the home			
3	Fire Exits available and free of clutter			
4	Refrigerator and Stove are working in the home			
5	Not using space heaters			
6	Electrical Sockets not overused with extension cords			
7	Patient not smoking in bed			
8	Is cautious about electrical heating pads			
	Bathroom Safety			
1	No Throw Rugs in Bathroom			
2	Safety bars present and in good condition			
3	Lighting Adequate			
4	Shower Chair in bathroom or No slip mat			
	Medication Use			
1	Keeps all medication in original bottle or medication box			
2	Has a medication schedule			
3	Stores Medication appropriately			
4	If Diabetic, has a working blood sugar testing device and tests per MD orders			

Recommendations:_____
_____

As of the date of this evaluation, I attest that this home is a safe environment for nursing care.

X_____ **Date:**_____
Representative Signature

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