

Patient Name:		D.O.B.	
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HOME SAFETY EVALUATION

ENTRY AREAS	Yes	No / Plan	OTHER ROOM	Yes	No / Plan
Free of clutter / obstacles			Light switch at entry to room		
Carpet/rugs firmly attached			All light bulbs working (60 watts)		
Well lit			Wheelchair accessible		
Door sills level			Floors free of clutter / obstacles		
Door opens easily			Electrical cords out of path		
Irregular stairs marked			Chairs firm with sturdy holds		
BATHROOM(S)	Yes	No / Plan	STAIR	Yes	No / Plan
Night-light			Light switches at top/bottom of stairs		
Wheelchair accessible			Irregular stairs marked		
Floor clear of water/obstacles			Sturdy railing both sides of stairs		
Elevated toilet seat w/bars			Stairs free of obstacles		
Safety rails in shower/toilet			Carpet/runners firmly attached		
Shower or bath chair/bench			Treads have non-skid surfaces		
Tub non-slip strips/suction mat			Can patient maneuver stairs?		
Non-slip mat beside tub			HALLWAYS	Yes	No / Plan
Hand-held shower head			Light switches on both ends		
Long handled sponge/soap			Night-light		
Toiletries/towels within reach			OUTSIDE	Yes	No / Plan
BEDROOM(S)	Yes	No / Plan	Lights on walk space outside		
Light switch at entrance			Entrances/walking areas clear		
Lamp or light next to bed			Pathways clear of debris		
Telephone next to bed			Even surfaces on walkways		
Bed easy to get in/out			Hand rails on elevated surfaces		
Path from bed to bathroom			Traction material available (sand)		
Night-light			GENERAL	Yes	No / Plan
KITCHEN	Yes	No / Plan	Stairs in/out - rails both sides		
Brightly lit work areas			Emergency call bell in place		
Common items at shoulder height			Phones near floor level in rooms		
Heavier items at waist height			Water temperatures low (by touch)		
FIRE SAFETY	Yes	No / Plan	Equipment? Problems:		
Smoking materials			No pets to trip over		
O ₂ in home			Flashlights accessible in all rooms		
Smoke detector(s) working			Loose Scatter rugs		

Patient/Family/Caregiver able to understand and follow safety instructions? Yes No

Comments/Plan: _____
