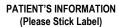


Form no.: HIM-PMR-N07

PATIENT'S INFORMATION (Please Stick Label)

## **HOME ASSESSMENT CHECKLIST**

Home Address:								
	me of Person Performe me of Person Performe				Date:			
(If	Applicable)	Acceptable	Date Assessed	Action Plan	Date Re-Assess (If Applicable )			
	Household Safety							
	Overall condition of the house is good and clean.	☐Yes						
		□No						
	Home has adequate lighting throughout	☐Yes						
		□No						
	Patient has access to a phone in an emergency	☐Yes						
		□No						
	Emergency phone numbers easily located	☐Yes						
		□No						
	Patient has a caregiver who stay in the same house	☐Yes						
		□No						
	There is a hospital/clinic within a reasonable	☐Yes						
	distance	□No						





	Acceptable	Date Assessed	Action Plan	Date Re-Assess (If Applicable )					
Storage									
Home has fridge which is suitable to store the	☐Yes								
diluted medication	□No								
Refrigerated is clean and adequate space to	Yes								
store the medication	□No								
Home has a dedicate cupboard/ drawer to	Yes								
store consumable items	□No								
Equipment									
Blood Pressure	Yes	_4							
Monitoring Set	□No								
		Fall Safe	ty						
Furniture is arranged for good traffic flow	Yes								
-	□No								
Floors and hallways are free of clutter and	Yes								
possible hazards	□No								
All rugs are secure or have been removed	Yes								
nave been removed	□No								
Showering facilities are equipped with a non-	Yes								
skid surface	□No								
Signature: Name: Date: Time:									