RISK ASSESSMENT FORM

Name: ___________________________ Address: ____________________________________

Date Completed: _________________ Person Completing Form: ____________________

These are items to be considered when assessing a person's risk of injury while in bed, however, these questions are not all inclusive. Each individual should be reviewed or his or her unique needs:

Check

Yes               No

1. Is the person able to get out of bed? ___  ____
   If yes, is the person at risk of falling without assistance? ___  ____

2. Does the person have the ability to move around in bed? ___  ____
   Does he/she move around without assistance? ___  ____
   Is he/she able to roll from back to stomach and vice versa? ___  ____

3. Does the person have any of the following medical conditions?
   Does he/she have seizures? ___  ____
   Does he/she have osteoporosis? ___  ____
   Does he/she have physical anomalies or contractures? ___  ____
   If yes do any of the above affect the person’s in-bed behavior? ___  ____

4. Is the person on any medication that could affect physical?
   and/or cognitive functioning while in bed? ___  ____

5. Does the head of the bed need to be elevated? ___  ____
   If yes, will the elevation increase the probability that the person may fall out of bed? ___  ____

6. Is the person able to communicate distress? ___  ____

7. What type of bed is being used?
   Hospital? ___  ____
   Twin? ___  ____
   Full? ___  ____

8. No Roll Mattress? ___  ____

9. Comments/Recommendation __________________________________________
   __________________________________________________________________
   Recommendation: ___________________________________________________

Review/Approved By: __________________________ Date: ___________________

(Site Registered Nurse)