

Home Safety Evaluation Checklist - Instructions: Patient Completes at Surgeon Office

Patient Name: _____ Age: _____ Gender: F M Height: _____ Weight: _____

Total Joint Replacement Surgery for: Hip Knee Right Left Surgeon: _____

Living Situation

- Single level House Condo
 Multi-level Apartment Facility (specify): _____

Number of steps to the most accessible door to your home? _____

Do those stairs have handrails? Yes No Not Applicable

Which side for going **up**? Left Right Not Applicable

How many steps inside your home? _____ or None

If your home is multi-level, is your bedroom, on the main floor? Yes No Not Applicable

If not, is it possible to arrange for sleeping accommodations on the main level? Yes No Not Applicable

Do you have pets at home? Yes No Not Applicable

Can you make arrangements for his/her/them after your discharge? Yes No Not Applicable

What type of bed do you have? Flat Adjustable Hospital Bed Height: _____

Do you have access to a bathroom near where you will sleep? Yes No Half Full

Bathroom Set Up:

Bathing:

- Tub & shower combo Tub only Shower stall only
 Grab bars to hold on to Shower chair Tub transfer bench

Toileting: Toilet seat is:

- Level with my knee Already raised by an extension seat on top
 Higher than my knee I use or have a bedside commode
 Below the level of my knee

Assistive Devices: Which device do you use (more often than not)

- | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Walker:
<input type="checkbox"/> Front wheels only
<input type="checkbox"/> 4 wheels and a seat
<input type="checkbox"/> No wheels | <input type="checkbox"/> Wheelchair:
<input type="checkbox"/> Manual
<input type="checkbox"/> Electric | <input type="checkbox"/> Cane:
<input type="checkbox"/> Single point
<input type="checkbox"/> Quad cane (4 prongs) | <input type="checkbox"/> Scooter
<input type="checkbox"/> None
<input type="checkbox"/> Other (specify): _____ |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|

Discharge Address: _____

Who lives with you in your home? _____

Do you have caregiver responsibilities for someone else, and have you made arrangements for the care of them? _____

When you return home, you are likely to need help with meals, laundry, pets, shopping and errands. You may also need help with daily activities like showering, dressing, going to the bathroom and even walking.

Who will be your support person/caregiver at discharge?

Name: _____ Relationship: _____

Phone (Home): _____ Phone (Cell): _____

How much help can they provide? _____

How many hours per day will they be with you? _____

(If you don't have a caregiver, someone can talk with you about the costs of services and ways to make these arrangements)

Who will provide your transportation to home at time of discharge? _____

Patient: _____ Phone (Home): _____ Phone (Cell): _____

Patient Signature: _____ Date: _____

Castle Medical Center Kailua, Hawaii PATIENT ID

HOME SAFETY EVALUATION CHECKLIST



PATIENT QUESTIONNAIRE

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