

## Risk Assessment Evaluation and Planning Worksheet

Consumer Name:		Date of Discussion:		Date of Note:	
Participants:					
Significant Risk Factors in the Consumer's Life	Are Risks Present?		Description of the Risk, Circumstances, and Frequency		Interventions Required to Eliminate or Minimize Risk
	Yes	No			
<b>1. FUNCTIONAL STATUS</b>					
a. Eating	<input type="checkbox"/>	<input type="checkbox"/>			
b. Ambulation	<input type="checkbox"/>	<input type="checkbox"/>			
c. Transfers	<input type="checkbox"/>	<input type="checkbox"/>			
d. Toileting	<input type="checkbox"/>	<input type="checkbox"/>			
<b>2. BEHAVIORAL</b>					
a. Self-Abuse	<input type="checkbox"/>	<input type="checkbox"/>			
b. Aggression Toward Others or Property	<input type="checkbox"/>	<input type="checkbox"/>			
c. Use of Physical/Mechanical Restraint	<input type="checkbox"/>	<input type="checkbox"/>			
d. Emergency Drug Use	<input type="checkbox"/>	<input type="checkbox"/>			
e. Psychotropic Medications	<input type="checkbox"/>	<input type="checkbox"/>			
<b>3. PHYSIOLOGICAL</b>					
a. Allergies (medications or other)	<input type="checkbox"/>	<input type="checkbox"/>			
b. Anticonvulsant Medications	<input type="checkbox"/>	<input type="checkbox"/>			
c. Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
d. Bowel Function	<input type="checkbox"/>	<input type="checkbox"/>			
e. Cardiac Conditions	<input type="checkbox"/>	<input type="checkbox"/>			
f. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
g. Gastrointestinal Conditions	<input type="checkbox"/>	<input type="checkbox"/>			
h. Medically Required Restraints (bed rails, postural supports, seat belts on wheelchairs)	<input type="checkbox"/>	<input type="checkbox"/>			
i. Nutrition	<input type="checkbox"/>	<input type="checkbox"/>			
j. Respiratory Conditions	<input type="checkbox"/>	<input type="checkbox"/>			
k. Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
l. Skin Breakdown	<input type="checkbox"/>	<input type="checkbox"/>			
m. Treatments	<input type="checkbox"/>	<input type="checkbox"/>			
<b>4. SAFETY</b>					
	<b>Yes</b>	<b>No</b>			

a. Injuries	<input type="checkbox"/>	<input type="checkbox"/>		
b. Falls	<input type="checkbox"/>	<input type="checkbox"/>		
c. Community Mobility	<input type="checkbox"/>	<input type="checkbox"/>		
<b>5. OTHER</b>	<b>Yes</b>	<b>No</b>		
a.	<input type="checkbox"/>	<input type="checkbox"/>		
b.	<input type="checkbox"/>	<input type="checkbox"/>		
c.	<input type="checkbox"/>	<input type="checkbox"/>		

**Instructions:** Under each specific area, list the Significant Risks identified; indicate “yes” or “no” as to whether a significant risk has been identified in the listed category; indicate “yes” or “no” whether training/service plans are present for the specific risk; if training/service plans have been developed, indicate the training/area; and briefly indicate a summary of the intervention required to eliminate or minimize the risk. (Taken from the Columbus Organization).