Dr. Robyn RM Gershon, Principal Investigator
Columbia University Mailman School of Public Health

-DRAFT-

Code: ___________

Household Safety Checklist

Today's Date: ___________

Did your patient sign the Consent Form: ☐ Yes **What time did you start the survey?** ____________

A. Information on your patient:

1. Age: ___________ 2. Gender (M/F): _________

3. Can your patient walk without help (e.g., a person or thing)? ☐ Yes ☐ No

4. What is your patient's overall health status (circle): Poor Fair Good Excellent

5. How many people live in the home: ________ Please list them: ____________________________________

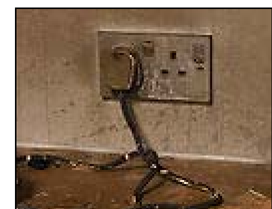
6. Do you know the medicines (prescription & nonprescription) your patient takes daily? ☐ Yes ☐ No ☐ N/A

7. How does your patient keep track of their medicines now?
   - ☐ "Pre-poured" or placed in a pillbox (see picture)
   - ☐ Medicines lined up
   - ☐ Other method
   - ☐ No method to keep track

8. Does patient keep any medicine in the home that they are no long taking? ☐ Yes ☐ No

9. Does the patient use a hearing aid? ☐ Yes ☐ No

B. Please check if any of these hazardous conditions or safety risks ARE found in your patient's home:

10☐ Poor lighting	13☐ Mold or fungus
11☐ Loose or worn-out rugs or carpets	14☐ Dangerous space heater (uses flammables)
12☐ Uneven or slippery floors	15☐ Dangerous electrical cords (easily tripped over, overloaded outlets, damaged cords) 

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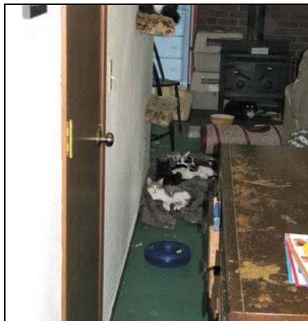
Code: ___________

16☐ Excessive dust or animal hair

17☐ Awkwardly placed furniture (blocking exit)

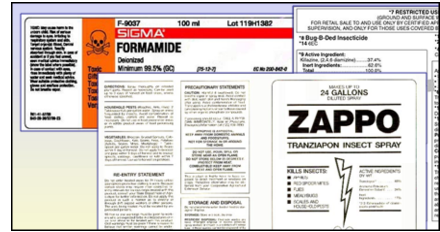


18☐ Excessive Clutter (it might block the exit out)

19☐ Food not generally stored in a sanitary manner

20☐ Trash builds up in the home

21☐ Cleaning products and other potential poisons that are **not** in the original containers (original labels are not in place)



22☐ Non-food and food items kept in same cabinet

23☐ Stove knobs hard to reach

24☐ Flammables (towels, curtains, paper) near stove tops

25☐ Rotten food or milk in the home

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26☐ Threat of violence, like aggressive dogs and other pets, neighbors, or weapons

28☐ Excessively loud noise in the home (from inside or outside the home or apartment)

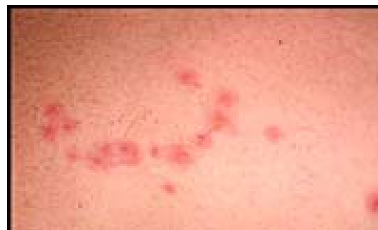
27☐ Doors are lacking good lock (e.g., dead bolts, chain lock, peep hole, etc.)

29☐ Signs of cockroaches in the home

30☐ Signs of other bugs in the home like bed bugs, fleas, or lice

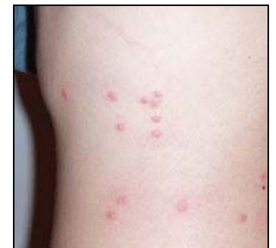
Bed Bugs:

Bed Bug Bites:



Lice:

Flea Bites:



31☐ Signs of rats or mice in the home

32☐ Unsafe use of smoking materials

C. Please check if these safety items ARE PRESENT in your patient's home:

33☐ Carbon monoxide alarm in the home

34☐ Smoke alarm in the home

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35☐ Grab bars to get in/out of the shower/bathtub

36☐ Fire extinguisher in the home

37☐ If yes, is the pressure gauge arrow in the green section (i.e., is it working)

38☐ Non-slip shower mat or pads in the shower/bathtub

39☐ Non-slip rug on the bathroom floor next to the shower/bathtub

40☐ Emergency contacts list available (e.g., family, doctor, superintendent, etc)

EMERGENCY! Phone List

Parent @ work_______________
Neighbor_______________
Police_______________
Fire Department_______________
Gas Company_______________
Electric Company_______________
Water Company_______________
Poison Control_______________
Doctor_______________
Dentist_______________

D. Please check if the following safety and medical devices ARE in your patient's home:

41☐ Safe lifting device
If yes, have you been trained to use it?
☐ Yes ☐ No

42☐ Needles and other sharps
If yes, is there a sharps container?
☐ Yes ☐No

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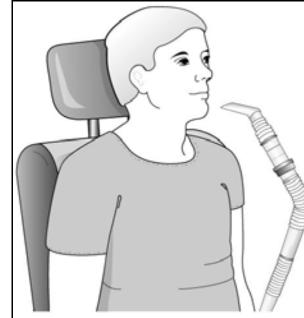
43☐ Oxygen tank
If yes, were you trained to use/store/handle it?
☐ Yes ☐ No

44☐ Portable toilet
If yes, were you trained to assist patient in its use?
☐ Yes ☐ No

45☐ Wheelchair
If yes, were you trained to assist patient in its use?
☐ Yes ☐ No

46☐ Cane
If yes, were you trained to assist patient in its use?
☐ Yes ☐ No

47☐ Ventilator
If yes, were you trained to assist patient in its use?
☐ Yes ☐ No



48☐ Nebulizer
If yes, were you trained to assist patient in its use?
☐Yes ☐ No

49☐ Walker
If yes, were you trained to assist patient in its use?
☐ Yes ☐ No

50☐ Other
Please list: ______________________
If yes, were you trained to assist patient in its use?
☐ Yes ☐ No

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E. Please answer these few questions about taking this survey.

51. What time did you finish the survey?

    ____

52. Did the training session help you to complete this checklist for your patient?

    Yes / No (Circle one)

53. Was your patient interested in the goody bag?

    Yes / No (Circle one)

54. Did your patient find the fact sheet (resources list) helpful?

    Yes / No (Circle one)

55. How easy was it to use this survey?

    Easy Moderate Difficult (Circle one)

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