GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION
OFFICE ON DISABILITY AND AGING

RISK ASSESSMENT TOOL

NAME: _____ DATE: _____

AGENCY: _____ CASE MANAGER_____

INSTRUCTIONS: Place a check mark beside any deficits that the participants displays, verbalizes, or has a noted history. Four or more selected characters trigger a risk.

CHECK (√)	TRIGGER DEFICIT
	Falls/Bruises
	Behavior symptoms
	Cognitive Impairments
	ADL decline
	IADL decline
	Vision deficit
	Hearing deficit
	Dehydration
	Pain/discomfort
	Rehabilitation
	Assistive devices
	Dialysis
	Medications x 5
	Infections
	Communications
	Aphasia
	Paralysis
	Immobility
	Bedridden
	OTHER

PARTICIPANT AT RISK FOR:

_____

RECOMMENDATIONS FOR MITIGATION:

_____

_____

_____

Signature: _____ Date: _____
Case Manager

Signature: _____ Date: _____
Registered Nurse

Developed March 5, 2007