QUARTERLY HOME, SAFETY, AND HEALTH REVIEW

Name:	
Address:	
City:	State:
Zip:	
Phone:	EMAIL:

Support Coordinator:	
Agency:	
Address:	
City:	State:
Zip:	
Phone:	

Date of Review:	

1. The neighborhood is free from disturbing noises, reverberations, and health hazards such as adverse environmental conditions, dangerous walks and steps, instability, flooding, poor drainage, septic tank backups, sewage hazards or mudslides, abnormal air pollution, smoke or dust, excessive accumulation of trash, or fire hazards **Y N N/A**
2. No danger of tripping in stairways, halls, porches, or walkways **Y N N/A**
3. Residence is free of vermin, rodents, or insect infestations **Y N N/A**
4. Residence is free of maintenance issues such as a leaky roof, loose door knobs, torn screens, etc. No major defects in the walls, ceiling, or floors (floors do not move when walking) **Y N N/A**
5. Residence is free of unpleasant odors such as urine, sewage, or mold **Y N N/A**
6. There are no visible safety hazards such as empty light sockets, frayed electrical cords, discoloration or exposed wires at electrical outlets, or excessive use of extension cords **Y N N/A**
7. If dwelling was built before 1978 and houses children 7 years or younger, there has been an inspection for lead based paints **Y N N/A**
8. Doors open, latch, and lock properly. Exterior doors have deadbolts. Locks that are present can be easily manipulated by the consumer **Y N N/A**
9. There is at least one window in each living and sleeping area. Windows have screens and locks that are easily manipulated by the consumer. Windows have adequate coverings to provide with needed privacy **Y N N/A**
10. Bathroom has at least one opening window or exhaust fan **Y N N/A**
11. Floor coverings are appropriate, acceptable, and safe (there is no danger of tripping) **Y N N/A**

QUARTERLY HOME SAFETY, AND HEALTH REVIEW, page 2 **Consumer Name:**
Date of review:

12. There are at least two electrical outlets (one can be overhead) in the living area, kitchen, and each bedroom **Y N N/A**
13. There is a ceiling or wall mounted light fixture in the kitchen and bathroom **Y N N/A**
14. There is adequate lighting throughout the residence to carry out normal activities **Y N N/A**
15. There is adequate and functional heating and cooling with adequate ventilation (unvented room heaters that burn gas, oil, or kerosene are not acceptable) **Y N N/A**
16. The residence is free from dangerous levels of air pollution from carbon monoxide, sewer gas, fuel gas, dust etc. **Y N N/A**
17. Plumbing is in good working order with a flushing toilet in a private bathroom with a fixed basin and tub or shower, both with hot (not over 120 degrees F) and cold water. Kitchen sink is present with both hot (not over 120 degrees F) and cold water **Y N N/A**
18. Water supply is free from contaminants **Y N N/A**
19. Nonskid surfaces are present in all bath tubs and showers. If tub/shower does not have a nonskid surface, removable rubber mats or adhesive strips are acceptable **Y N N/A**
20. If appropriate, the grab bars are mounted in appropriate locations **Y N N/A**
21. Kitchen has suitable space to store, prepare, and serve food in a sanitary manner. Stove and refrigerator are present and in working condition (all burners on gas stove function, pilot lights are lit, and no gas odor is present). **Y N N/A**
22. Garbage can/bin is present **Y N N/A**
23. First aid kit is complete and available **Y N N/A**
24. At least one smoke detector is mounted in an appropriate place and functions **Y N N/A**
25. A portable fire extinguisher is located in the kitchen and can demonstrate knowledge and ability to use it **Y N N/A**
26. Consumer can identify closest fire exit and alternative exit and can identify procedures to follow in case of a fire **Y N N/A**
27. Consumer has a plan in place to deal with hurricanes and other natural disasters **Y N N/A**
28. Consumer understands causes and prevention of AIDS and other sexually transmitted diseases **Y N N/A**
29. Review with consumer “Notice of On Call System” form **Y N N/A**
30. Consumer has emergency numbers readily accessible **Y N N/A**
31. Review with consumer “Grievance Procedure” form **Y N N/A**
32. Consumer expresses satisfaction with service as currently provided **Y N N/A**

QUARTERLY HOME SAFETY, AND HEALTH REVIEW, Page 3 Consumer Name:
Date of Review:

Provide an explanation of an “N/A” responses:

Provide an explanation of a “No” responses. Include a specific plan to address with a target completion date:

QUARTERLY HOME SAFETY, AND HEALTH REVIEW, Page 4 Consumer Name:
Date of Review:

CURRENT MEDICAL PROVIDERS:

(Provide the address and contact information for new providers only)

Physician:		
Specialty:		
Address:		
City	| State:	|Zip:
Phone:	|Fax:	

Physician:		
Specialty:		
Address:		
City	| State:	|Zip:
Phone:	|Fax:	

Physician:		
Specialty:		
Address:		
City	| State:	|Zip:
Phone:	|Fax:	

Physician:		
Specialty:		
Address:		
City	| State:	|Zip:
Phone:	|Fax:	

CURRENT MEDICATIONS:

Name:	|Dosage:	|Frequency:
Prescribing Physician:		
Reason for Medication:		

Name:	|Dosage:	|Frequency:
Prescribing Physician:		
Reason for Medication:		

QUARTERLY HOME SAFETY, AND HEALTH REVIEW, Page 5 Consumer Name:
Date of Review:

Name:	|Dosage:	|Frequency:
Prescribing Physician:		
Reason for Medication:		

Name:	|Dosage:	|Frequency:
Prescribing Physician:		
Reason for Medication:		

Name:	|Dosage:	|Frequency:
Prescribing Physician:		
Reason for Medication:		

(Provide address and contact information for pharmacist only if new provider)

Pharmacist:		
Pharmacy:		
Address:		
City:	|State:	|Zip:
Phone:	|Fax:	

MEDICAL VISITS:

Examinations	Recommended Frequency	Last Appointment	Next Appointment
Physical	Annual		
Dental	Semi-Annual		
Eye exam	Annual (Bi-annual if no glasses		
Tetanus	Every 10 years		
Prostrate (Male)	Annual		
Pap Test (Female	Annual		
Mammogram (Female)	Annual		

MEDICAL VISITS (Continued):

Other Examinations:	Date:	Reason for visit:

QUARTERLY HOME SAFETY, AND HEALTH REVIEW, Page 6 **Consumer Name:**		
Date of Review:		

MEDICAL VISITS (Continued):

Other Examinations:	Date:	Reason for Visit

RELATIONSHIP MAP (USE OF NATURAL AND GENERIC SUPPORTS)

Name:	**|Relationship:**
Address:	**|Phone:**
Type of Support:	

Name:	**|Relationship:**
Address:	**|Phone:**
Type of Support:	

Name:	**|Relationship:**
Address:	**|Phone:**
Type of Support:	

Name:	**|Relationship:**
Address:	**|Phone:**
Type of Support:	

Name:	**|Relationship:**
Address:	**|Phone:**
Type of Support:	

SL Coach Signature/Date:
Consumer Signature/Date: