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)*

☐ Walker:	☐ Wheelchair:	☐ Cane:	☐ Scooter
☐ *Front wheels only*	☐ *Manual*	☐ *Single point*	☐ *None*
☐ *4 wheels and a seat*	☐ *Electric*	☐ *Quad cane (4 prongs)*	☐ *Other (specify):* _____
☐ *No wheels*			

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: _____