Capital Health

Continuing Care

Pre-visit Risk Identification Screening Questions

Name		Health Card #	

QUESTION FOR REFERRAL SOURCE Comments	*To your knowledge, is there any reason a home visit to this client may pose a risk to staff?*	☐ Yes ☐ No
ANIMALS, PETS Comments	Do you have any pets? If so, client please secure pet in another room when staff visit.	☐ Yes ☐ No
PRESENCE OF OTHERS Comments	Does anyone else live in your home, and will they be present if a care provider is there? If so, when?	☐ Yes ☐ No
GUNS or OTHER WEAPONS Comments	Do you have any guns or other weapons? If so, do you keep them locked?	☐ Yes ☐ No
SMOKERS Comments	Do you or others in your home smoke? If so, please refrain from smoking during staff visits.	☐ Yes ☐ No

Signature at Intake **Date**

Comments by Care Coordinator

Signature of Care Coordinator **Date**