

Instructions:

Complete upon admission, thirty days after admission, quarterly and at significant change, or per facility policy. Review *Potential Risk Factors and Resident Status* and check (✓) YES or NO under the appropriate assessment date. On Side Two, complete the corresponding *Summary of Assessment*.

Admission Date: _____ / _____ / _____

ELOPEMENT RISK ASSESSMENT



POTENTIAL RISK FACTORS/RESIDENT STATUS	ASSESSMENT DATES	ASSESSMENT DATES			
		1	2	3	4
Is the resident cognitively impaired with poor decision-making skills (i.e. intermittent confusion, cognitive deficits or disoriented)? (If YES, comment on Side Two.)	NO				
	YES				
Does the resident have a pertinent diagnosis of Dementia, OBS, Alzheimer's, Delusions, Hallucinations, Anxiety Disorder, Depression, Manic Depression or Schizophrenia? (If YES, comment on Side Two.)	NO				
	YES				
Does the resident ambulate independently, with or without the use of an assistive device (including a wheelchair)? (If YES, comment on Side Two.)	NO				
	YES				
Does the resident have any hearing, vision or communication problems? (If YES, comment on Side Two.)	NO				
	YES				
Does the resident have a history of: (If yes, place a (✓) in the top portion of box and record # of times in lower portion)	Elopement while at home				
	NO				
	YES	#	#	#	#
	Leaving facility without need of supervision				
	NO				
	YES	#	#	#	#
Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near exit door? (If YES, comment on Side Two.)	NO				
	YES				
Does the resident wander aimlessly (i.e. confused, moves without purpose, may enter others' rooms and explores others' belongings)? (If YES, comment on Side Two.)	NO				
	YES				
Is the wandering behavior a pattern or routine tied to resident's past (i.e. worked 3rd shift, taking long walks or seeking someone they cannot find)? (If YES, comment on Side Two.)	NO				
	YES				
Has the resident been recently admitted or re-admitted (within past 30 days) and not accepting the situation? (If YES, comment on Side Two.)	NO				
	YES				
Does the resident receive any medications that increase restlessness and agitation? (If YES, comment on Side Two.)	NO				
	YES				
Is this a new behavior, has there been any changes in the resident's status or routine (i.e. medication, illness, pain, infection, personal tragedy)? (If YES, comment on Side Two.)	NO				
	YES				
Has the family/responsible party voiced concerns that would indicate the resident may have wandering tendencies or try to leave? (If YES, comment on Side Two.)	NO				
	YES				

Form # MP5472 3/04

Reorder From: MED-PASS 800-438-8884

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XFM 11298R

Resident Name	Medical Record #	Room #	Physician
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SUMMARY OF ASSESSMENT

1 Resident is not at risk for elopement at this time.
 Resident is at risk for elopement, as evidenced by: _____

Appropriate interventions have been: initiated reviewed modified. **Intervention Numbers:** _____
 Physician orders requested. (See PO dated _____) Family/Responsible Party/Resident notified per facility policy. Plan of care updated.
 Additional Comments: _____

Signature(s) / Title(s) _____ Date _____

2 Resident is not at risk for elopement at this time.
 Resident is at risk for elopement, as evidenced by: _____

Appropriate interventions have been: initiated reviewed modified. **Intervention Numbers:** _____
 Physician orders requested. (See PO dated _____) Family/Responsible Party/Resident notified per facility policy. Plan of care updated.
 Additional Comments: _____

Signature(s) / Title(s) _____ Date _____

3 Resident is not at risk for elopement at this time.
 Resident is at risk for elopement, as evidenced by: _____

Appropriate interventions have been: initiated reviewed modified. **Intervention Numbers:** _____
 Physician orders requested. (See PO dated _____) Family/Responsible Party/Resident notified per facility policy. Plan of care updated.
 Additional Comments: _____

Signature(s) / Title(s) _____ Date _____

4 Resident is not at risk for elopement at this time.
 Resident is at risk for elopement, as evidenced by: _____

Appropriate interventions have been: initiated reviewed modified. **Intervention Numbers:** _____
 Physician orders requested. (See PO dated _____) Family/Responsible Party/Resident notified per facility policy. Plan of care updated.
 Additional Comments: _____

Signature(s) / Title(s) _____ Date _____

POTENTIAL INTERVENTIONS

Select appropriate interventions and place the corresponding numbers in the Intervention numbers field above.

1 Personal safety alarm devices	11 Recreational activities
2 Exit and stairwell alarms	12 Music
3 Secured unit	13 Exercise
4 Frequent monitoring. Check every _____	14 Personalization of room with familiar objects and photographs
5 Keep behavior logs	15 Decorate doors and door knobs to look like something else
6 Review medications	16 Use of visual barriers: stop sign, ribbons, tape
7 Tapes with reassuring messages from family	17 Photograph on wander list
8 Identification bracelet	18 Staff aware of resident's wander risk
9 Utilization of check in/out log	19 Other _____
10 Bed alarms	20 Other _____

Resident Name	ID #	Room #	Physician
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