HOME VISIT CHECKLIST

DEMOGRAPHICS

PATIENT NAME	DoB: ___/___/_____
PATIENT ADDRESS	
PATIENT PHONE NUMBER(S)	1)　　　　　　　　　　　　　Confirmed working: Yes No 2)　　　　　　　　　　　　　Confirmed working: Yes No
PARTNER (OPTIONAL)	Name: _____　Number(s): _____ Address: _____　Confirmed working: Yes No
LIVING ARRANGEMENTS	House Apartment SNF/LTC Temporary Vacation Other: _____ Others present in household: _____
MODALITY	CAPD APD HHD　　　　　　　　　　　　Nocturnal: Yes/No
EQUIPMENT NUMBER(S)	
TYPE OF VISIT	Initial First at Home Re-training Annual Other: _____ Date: ___/___/_____

HOME ASSESSMENT

EXTERIOR	Number of stairs: _____　Well-lit: Yes No　House/unit numbers clear: Yes No
HOME EXITS	Number: _____　Unobstructed: Yes No Other: _____
DIALYSIS LOCATION	
SUPPLY STORAGE	Supply storage plan:
CLEANLINESS	
PETS	
PHOTOS TAKEN	
CONCERNS & ACTION PLAN	

ELECTRICAL & WATER

OUTLETS	**Tested**: Pass Fail　Other: _____
INTERNET CONNECTION	
HANDWASHING SINKS	**Location(s) relative to treatment**: Same floor Different floor Both Other: _____
HYGIENE	Soap (liquid) Hand sanitizer Paper towels Cleaning supplies: _____
WATER (HHD)	Samples: Tap Monthly Quarterly Repeat　Sent to lab (initial/date): _____
SOURCE & DRAINS (HHD)	City Well　　Incoming connection location/type: _____ 　　　　　　Outgoing connection location/type: _____
EFFLUENT DISPOSAL (PD)	Bags/bucket drained to: _____　Drain line to: _____
CONCERNS & ACTION PLAN	

SAFETY

EMERGENCY CONTACT #1	Name: _____ Number(s): _____ Relationship: _____ Confirmed working: Yes No
EMERGENCY CONTACT #2	Name: _____ Number(s): _____ Relationship: _____ Confirmed working: Yes No
CLOSEST NEIGHBOR	Name: _____ Number(s): _____ Address: _____ Confirmed working: Yes No
LOCAL FIRST RESPONDERS	Local police, fire, EMS department and number:
SMOKE & CO2 ALARMS	
LIGHTING	Adequate lighting: Yes/No Flashlight in treatment area: Yes/No
EMERGENCY SUPPLIES	"Emergency Go-Kit" Present: Yes/No PD Adaptor Present: Yes/No (HHD) Bleeding Kit Present: Yes/No
BLOOD LEAK DETECTION (HHD)	
EVACUATION PLANS	

ACTION

TREATMENT OBSERVED	Yes/No
PROCEDURES OBSERVED	Type:
MEDICATION RECONCILIATION	Changes:
DIALYSIS MEDICATIONS DATES CHECKED	Yes/No Present in home: Discards:
SUPPLIES DISTRIBUTED	
ACCESS CHECK PERFORMED	
VISIT NOTES	