PARTICIPANT RISK ASSESSMENT FORM

Health Care 4 You

Participant's Name:	
Participant's Address:	
Assessor Name:	Date of Assessment:

GENERAL INFORMATION:		
	Yes	**No**
1. Has the Care Recipient ever exercised force, towards any person including a caregiver that caused or could have caused injury?	☐	☐
2. Does the Care Recipient have a diagnosed mental illness (including paranoia)?	☐	☐
3. Is the Care Recipient currently taking any mental health related medication?	☐	☐
4. Does the Care Recipient collect/hoard items in their room/house?	☐	☐
5. If so, do the collected items pose a potential fire risk?	☐	☐
6. Does the Care Recipient smoke?	☐	☐
7. Does the Care Recipient have a history with substance abuse (illicit drugs/alcohol)?	☐	☐
8. Can the Care Recipient effectively communicate their wants and needs to others?	☐	☐
9. Does the Care Recipient currently engage in or have a history of self-injurious behaviours/self-harm?	☐	☐
10. Is the behaviour of the Care Recipient unpredictable?	☐	☐
11. Is the Care Recipient likely to have access to weapons?	☐	☐
12. Does the participant have significant risk factors e.g living alone, isolated, impaired mobility or communication?	☐	☐

To what degree does the participant rely on our services? Explain below:

How would the participants' health and safety be impacted if their service was disrupted? Explain below:

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SIGNIFICANT RISKS REGARDING THE PARTICIPANT AND THEIR ENVIRONMENT

CHALLENGING BEHAVIOURS:

Select any current or historic challenging behaviours

	Yes	No
1. Verbal threats/actions	☐	☐
2. Physical threats/actions	☐	☐
3. Absconding	☐	☐
4. Mouthing/Eating inedibles	☐	☐
5. Unwilling to follow instruction	☐	☐
6. Overtly loud or noisy	☐	☐
7. Impulsive/Agitated	☐	☐

Are there any plans in place to targeting the participants' challenging behaviours?

Please detail including the persons responsible:

DETAILS OF RISK MINIMISING ACTIONS:

Item No.	Actions needed to reduce/remove risk	Complete Yes/No	If unable to complete action/s – report to the director for further advice before commencing services	
			Reported to:	Date:

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***Report any identified High Risks to* the manager *immediately for review and action before commencing services. ***

Notes:

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Control measures have been reviewed and no further risks have been identified Yes☐ No☐	Are further reviews required? No☐ Yes☐ When:	
Reviewer name:	Reviewer signature:	Date:
Record of subsequent reviews.		
Review date:	Reviewed by:	Description of any changes: