# INDIVIDUAL BED & SIDE RAIL ASSESSMENT

[ ]  **DDS Public Programs** [ ]  **Southbury Training School**

[ ]  **DDS Qualified Provider**      **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(agency name)**

## Name:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Assessment:      \_\_\_\_\_\_\_\_\_

**Address:**      **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- |
| **1** | Does the individual have a seizure disorder which would require side rails? | [ ]  **Yes** | [ ]  **No** |
| **2** | Does the individual have impaired muscle control that may compromise his or her ability to remain in bed without falling out? | [ ]  **Yes** | [ ]  **No** |
| **3** | Is the individual at significant risk for falls and injuries if he or she gets out of bed unattended? | [ ]  **Yes** | [ ]  **No** |
| **4** | Is the individual compromised in his or her ability to call for assistance when he or she wishes to get out of bed? | [ ]  **Yes** | [ ]  **No** |
| **5** | Does the individual have mental status changes that would place him or her at risk for injury (i.e., agitation, confusion, lethargy or behavioral issues)? | [ ]  **Yes** | [ ]  **No** |
| **6** | Does the individual need side rails in order to position himself or herself in the bed? | [ ]  **Yes** | [ ]  **No** |

Explain any “Yes” answer(s) or other rationale for bed side rails not listed above:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| 7 | Is there an alternative way to provide a safe sleeping arrangement for the individual without the use of side rails? | [ ]  Yes | [ ]  No |

Explain:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 8 | Based on the above criteria, the individual’s Planning and Support Team (PST), in consultation with his or her Primary Care Provider, have determined that bed rails are: |
| [ ]  Required for safety | [ ]  Not required for safety |
| 9 | Type of side rails recommended: |
| [ ]  Full rails | [ ]  2 half-rails | [ ]  Upper half-rail | [ ]  Padded full rails |
| [ ]  Both sides | [ ]  Right side only | [ ]  Left side only |  |

Healthcare provider’s agreement with this assessment is reflected in the current prescriber’s orders.

**Signatures: Date: Signatures: Date:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

Guardian/Legal Representative Team Member

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

### Team Member Team Member

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

Team Member Team Member