

Risk Assessment Tool (Part 2)

This form is to be used both at triage, and again after comprehensive assessment and at care review stage. It should be used in interim period when a risk issue is highlighted. Complete on all clients scoring 2 or more on risk to self/others. Tick whichever box is appropriate (Y for Yes, N for No, or ? for unknown) for each question.

The degree of risk is dependent on the total number of y and n responses. The higher the number the greater the risk.

1. Self Harm – Deliberate & Suicide							
	Y	?	N		Y	?	N
Depressed mood (subjective)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Past history of non-suicidal self-harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide plans made	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Action taken on plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous suicide attempt (<i>give details</i>):					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dangerous method (high risk to self and others i.e. irresponsibility)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discovery avoided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Final acts (notes etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Accidental Overdose							
	Y	?	N		Y	?	N
If yes, how many times?				Regular intravenous use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poly drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many times in last 90 days?			
History of past overdoses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has witnessed overdose(s) by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol involved?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injects alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Which were the main drugs involved?							

3. Harm to Others – Aggression							
	Y	?	N		Y	?	N
Past history of violence to others (may include sexual violence)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of provocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of regret	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts/threats of violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoid thoughts/delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Available weapon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Identified target	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prone to emotional arousal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relevant criminal record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Conflict			

4. Child Care							
	Y	?	N		Y	?	N
Responsible for child under 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Single parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Apparently intoxicated while solely responsible for child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Personal Safety – Self Neglect							
	Y	?	N		Y	?	N
Past history of self-neglect?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Long-term institutional care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the client reliant on others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<i>Cannot cope with or needs help or prompting in:</i>							
Budgeting/handling money/accommodation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doing weekly shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking care of personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cooking for self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homeless/no fixed abode (<i>give details</i>)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have there been any major events or issues in your life or those around you in the last 12 months?					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Risk in the Community							
	Y	?	N		Y	?	N
Drink-drive conviction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drives/operates as part of occupation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drives/works while intoxicated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uncaring/indifferent to risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic intoxication but still drives/works	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk/threat from others (<i>give details</i>)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of Risk				<i>Risk indicator – tick as appropriate</i>			
		High	Medium	Low	Nil		
For self harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
For harm to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
For personal safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Category of Risk	<i>Risk indicator – tick as appropriate</i>			
	High	Medium	Low	Nil
Risk to staff, clients and or residents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk to the public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there any significant evidence of risk in the following areas?

		Past	Current	
A	Risk of violence, harm to others	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Not Known <input type="checkbox"/>
B	Risk of suicide	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Not Known <input type="checkbox"/>
C	Risk of other self harm (please state)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Not Known <input type="checkbox"/>
D	Risk of neglect/vulnerability	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Not Known <input type="checkbox"/>
E	Risk to staff	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Not Known <input type="checkbox"/>
F	Risk of medication abuse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Not Known <input type="checkbox"/>

Further action recommended

Please Tick

A	None at this stage	<input type="checkbox"/>
B	Discussion with team members	<input type="checkbox"/>
C	Discussion with manager	<input type="checkbox"/>
D	Risk profile descriptive account	<input type="checkbox"/>
E	Risk management plan	<input type="checkbox"/>

Risk history – Describe below (include details of most serious harm caused description account; to self or others)

