UNIVERSITY OF VIRGINIA HEALTH SYSTEM

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

UVA CHILDREN'S HOSPITAL
RISK / THREAT SCREENING FORM

CONFIDENTIAL, FOR QUALITY IMPROVEMENT PURPOSES ONLY
KEEP AT NURSES STATION, AND PLACE IN FRONT OF MEDICAL RECORD IF PATIENT IS TRANSFERRED.
Page Security (PIC 1647) and fax to Security at 2-0995 when completed

Name of Patient _____

Date & time assessment performed _____

All "Yes" responses must be explained in space provided.

1. Location of initial assessment: ☐ Peds ED ☐ PICU ☐ 7C ☐ 7W ☐ KCRC ☐ CLINIC
2. Is the patient in police/Department of Social Services custody? ☐ YES ☐ NO
   Name of Custodian or case worker _____
3. Circumstances of admission (i.e. assault, trauma, abuse/neglect, or other)_____
   _____
4. Is there reason to believe that there is a continued threat to this patient or family? ☐ YES ☐ NO
   Explain:_____
5. Is there reason to believe that this patient or family is a threat to others? ☐ YES ☐ NO
   Explain:_____
6. Is this patient at risk for abduction? ☐ YES ☐ NO

   If this patient or family is at risk as indicated by a yes response to any of the above questions, please explain with protective or preventative measures will be taken to promote patient safety. Please include any detail long-term plan in progress notes of permanent medical record.

_____
_____
_____
_____

Social worker notified (if other than person performing assessment) _____

Page Security (PIC 1647) and fax to Security at 2-0995 _____

Name of Security officer notified _____

KCRC ONLY: Security or PCSM notified _____

When applicable, the patient and/or family may choose to limit visitation to a list of approved visitors (limit 12) and/or restrict certain persons (limit 12). Please indicate below. Security **must** be notified with any changes.

APPROVED VISITORS	RESTRICTED VISITORS
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name & Title of individual performing assessment _____