**Room Safety Checklist**

**Room #:**

**Patient in safe room? YES NO**

If **“NO”** please proceed:

Items for removal

* Trash Can: Date/time completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials of who completed\_\_\_\_
* Oxygen tank: Date/time complete\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials of who completed\_\_\_\_
* Chairs: Date/time completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials of who completed\_\_\_\_
* Supply cart:Date/time completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials of who completed\_\_\_\_
* Computer:Date/time completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials of who completed\_\_\_\_
* All removable cords:

 Date/time completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials of who completed\_\_\_\_

 Items to be secured in patient room with zip ties (if unable to be removed)

* Any non-removable cords

Date/time completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials of who completed\_\_\_\_

* Suction Date/time completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials of who completed\_\_\_\_
* Ophthalmoscope/Otoscope

Date/time completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials of who completed\_\_\_\_

Special Considerations:

Please list any items specific to patient that may need to be left in room (e.g. suction for autistic patients)