Tallahassee Memorial HealthCare
Adult Day Care Services
Wandering Risk Assessment

This is a screening tool to ensure the safety of our clients. Please check any statement that are true and input N/A (not applicable) if it is not true.

_____ 1. Has the client ever left and you were unable to find him/ her?
_____ 2. The client is restless, paces or makes repetitive movements?
_____ 3. Does the client state he/ she wants to go home regularly, even when at home?
_____ 4. Does the client have difficulty locating familiar places, such as bathroom or bedroom?
_____ 5. Has there been an increased level of agitation at night (sun downing)?
_____ 6. Do unusual facial expressions, tapping of the feet, shaking one or both legs represent the client’s anxiety level or feeling of discomfort?
_____ 7. Does the client not stay in the same place for too long?

__________________________________________  ____________________________________________________________________________
Client’s Name                                      Date

______________________________________________  ______________________________________
Client’s/ Caregiver’s Signature                   TMH ADC Program Coordinator