

Smoking Safety Evaluation

Resident _____ Date _____

	Adequate	Mild impairment	Severe impairment
Cognitive			
Communication			
Sensory			
Dexterity			
Motivation			
Mood / Behavior			

Has resident smoked without supervision before? yes no

If yes, were there any problems? _____

Has resident ever violated the facility's smoking policy? yes no

Have ashes or burns ever been observed on the resident's clothing? yes no

Task	Ability	Assistance required
Follow facility policy on location and time of smoking		
Light cigarette safely		
Hold cigarette safely		
Extinguish cigarette safely		

Notes: _____

Evaluation completed by _____ Date _____