

Safe Smoking Assessment Form

New Jersey Veterans Memorial Homes

Resident's Name: _____ Resident # _____ Room # _____

Date: _____ Diagnoses: _____

(Please circle Y or N, and add comments as applicable below ↓)

Does the resident know the location(s) of the designated areas for smoking? Y N

Can the resident get to these areas independently? Y N

When observed, can the resident independently light smoking materials safely?
(If no, explain) _____ Y N

Does the resident shake / have tremors while smoking? Y N

Does the resident fall asleep while smoking? Y N

Can the resident extinguish smoking materials completely in an appropriate receptacle?
(If no, explain) _____ Y N

Can the resident dispose of ashes or other tobacco-related residue appropriately?
(If no, explain) _____ Y N

Has the resident had any past accidents / incidents with smoking materials?
(If yes, explain) _____ Y N

Are there any visible burn marks on the resident's clothing / coat? Y N

Interdisciplinary Care Plan (IDCP) Team recommendations: _____

This resident is safe to smoke unsupervised, at this time: Y N

This resident requires 1:1 supervision while smoking: Y N

This resident requires a fire-resistant smoking apron while smoking: Y N

All smoking materials will be kept at the nurses' station (circle which ones ↓): Y N

Cigarettes / Pipe / Cigars / Electronic Smoking Device / Smokeless Tobacco / Matches / Lighter / Other

Resident notified of restrictions: Y N Comments: _____

Family or POA notified of restrictions: Y N Comments: _____

Staff notified of restrictions: Y N Comments: _____

A "Smoking Care Plan" is in place: Y N Comments: _____

IDCP Team Signatures: _____