

Safe Area For Everyone (S.A.F.E.) Patient Assessment

Our team wants to get to know your child and their unique needs. We know that every child is different, so please spend a few moments filling out the information below so we may provide the best care for your child.

Child's Name: _____ They like to be called: _____ Date of Birth: _____

MR# (lab fill in): _____ Current Height: _____ Current Weight: _____ Current Date: _____

Communication
Is your child able to communicate? <input type="checkbox"/> YES (mark all that apply): <input type="checkbox"/> Vocalizations <input type="checkbox"/> Electronic Device <input type="checkbox"/> Pictures <input type="checkbox"/> Sign Language <input type="checkbox"/> Other: _____ <input type="checkbox"/> NO (describe best ways for us to communicate with your child): _____

Potential Challenges
Does your child ever engage in challenging behavior that may be a danger to themselves or others? <input type="checkbox"/> YES (mark all that apply): <input type="checkbox"/> Hitting/Punching <input type="checkbox"/> Kicking <input type="checkbox"/> Biting <input type="checkbox"/> Pulling Hair <input type="checkbox"/> Scratching <input type="checkbox"/> Grabbing Clothing <input type="checkbox"/> Spitting <input type="checkbox"/> Head Hitting <input type="checkbox"/> Head Banging <input type="checkbox"/> Skin Picking <input type="checkbox"/> Eating/Chewing Non-Edibles <input type="checkbox"/> Other: _____ <input type="checkbox"/> NO
Does your child ever engage in challenging behavior that may be disruptive to the environment? <input type="checkbox"/> YES (mark all that apply): <input type="checkbox"/> Screaming <input type="checkbox"/> Breaking Items <input type="checkbox"/> Overturning Furniture <input type="checkbox"/> Throwing Items <input type="checkbox"/> Banging Surfaces <input type="checkbox"/> Swearing <input type="checkbox"/> NO
Do you believe that your child may attempt to run away or hide (when upset or even when calm)? <input type="checkbox"/> YES (please describe): _____ <input type="checkbox"/> NO
Are there any specific triggers that are likely to initiate your child's challenging behavior? <input type="checkbox"/> YES (mark all that apply): <input type="checkbox"/> Told They Can't Leave <input type="checkbox"/> Told They Can't Have/Do Something <input type="checkbox"/> Not Enough Interaction <input type="checkbox"/> Fear of Unknown <input type="checkbox"/> Routine/Ritual Disrupted <input type="checkbox"/> Medical Procedures <input type="checkbox"/> Needles <input type="checkbox"/> Tourniquet <input type="checkbox"/> Restraint <input type="checkbox"/> Other: _____ <input type="checkbox"/> NO

Sensory Needs
Does your child ever have negative responses to certain sensory experiences? <input type="checkbox"/> YES (mark all that apply): <input type="checkbox"/> Loud Noises <input type="checkbox"/> Waiting Areas/Crowded Spaces <input type="checkbox"/> Bright Lights <input type="checkbox"/> Other: _____ <input type="checkbox"/> NO
If it is helpful to introduce your child to medical supplies and devices in advance, example blood draw supplies (for touch/sensation) can be picked up at any NCH Laboratory Service Center location.

Approaches and Tools
Are you willing and able to assist with holding your child during the blood collection? <input type="checkbox"/> YES (please describe): _____ <input type="checkbox"/> NO
Social Stories that show each step of the blood draw process are available to download on the S.A.F.E. Program website.

Blanket Wrap
Blanket Wrap Option: <input type="checkbox"/> YES <input type="checkbox"/> NO

Distraction
Does your child benefit from distractions? <input type="checkbox"/> YES (mark all that apply): <input type="checkbox"/> Bubbles <input type="checkbox"/> Music Playing <input type="checkbox"/> Videos Playing <input type="checkbox"/> Singing <input type="checkbox"/> Other: _____ <input type="checkbox"/> NO
Please list your child's favorite toys, movies, cartoons, and activities: _____ Please bring your child's favorite toy or comfort item to the appointment.

Parent/Guardian Name(s): _____

Phone Number: _____ Email Address: _____

Completed forms can be emailed to LabSAFEProgram@Nationwidechildrens.org, faxed to our secure fax at (614) 355-4487, or dropped off at any of our Laboratory Service Centers listed on <https://www.nationwidechildrens.org/locations/laboratory-services>.