STOP AND WATCH TOOL 

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[ ]  **Mr** [ ]   **Mrs** [ ]  **Ms** [ ]  **Dr** [ ]  **Self-described**:

|  |  |  |  |
| --- | --- | --- | --- |
| Client Name |  | Date of Assessment |  |
| Name of person completing form |  | Contact number |  |

**Comments**

|  |  |  |  |
| --- | --- | --- | --- |
| **S** | **Seems different than usual**  | [ ]  Yes [ ]  No |  |
| **T** | **Talks less or irregular breathing (faster/slower)** | [ ]  Yes [ ]  No |  |
| **O** | **Overall needs more help** | [ ]  Yes [ ]  No |  |
| **P** | **Pain** | [ ]  Yes [ ]  No |  |
|  |
| **A** | **Ate less** | [ ]  Yes [ ]  No |  |
| **N** | **No bowl movement in 3 days, or diarrhea** | [ ]  Yes [ ]  No |  |
| **D** | **Drank less** | [ ]  Yes [ ]  No |  |
|  |
| **W** | **Weight change, swollen legs or feet** | [ ]  Yes [ ]  No |  |
| **A** | **Agitated or nervous more than usual** | [ ]  Yes [ ]  No |  |
| **T** | **Tired, weak, confused or drowsy** | [ ]  Yes [ ]  No |  |
| **C** | **Change in skin colour or condition** | [ ]  Yes [ ]  No |  |
| **H** | **Help with walking, transferring, toileting more than usual** | [ ]  Yes [ ]  No |  |

**Escalated to:**

**Action taken**: