

## **Geriatric Evaluation and Treatment Program**

### **Comprehensive Care for the Elderly Patient**

### **What is the Geriatric Evaluation and Treatment Program (GET)?**

The Geriatric Evaluation and Treatment Unit (GET) Program is a component of the Department of Family & Geriatric Medicine at the University of Louisville School of Medicine. It focuses on the testing, evaluation, and treatment of the complex medical, social and psychological disorders of the older adult.

As the first and only service of its kind in the Louisville area, the Geriatric Evaluation & Treatment Unit:

- has served as a model for innovative approaches to health care for the elderly since 1984.
- provides a training environment for professionals who have a special interest in geriatrics and gerontology.
- provides educational workshops to organizations in the community.

### **Why is there a need for GET?**

As the human body ages, it may be afflicted by a number of common, yet complicated diseases. Friends and family members of the older adult may notice a decrease in function, difficulty hearing or speaking clearly, periods of memory lapses or confusion, or other related symptoms that may be experienced by people over 62.

These symptoms can cause distress to the older adult who has led an active and independent life. Suddenly, he or she may have to make frequent trips to the physician, take prescription medications or employ the services of a visiting nurse or a social worker. As the person's ability to care for himself or herself lessens, hospitalization or a move into a nursing home may become imminent.

All of these changes – the physical maladies, the emotional upset that comes with dependence and the prospect of leaving one's home, and the chemical reactions of the prescribed drugs – each has its own effect upon the total well-being of the older person, and yet they are all interrelated. It is on this premise that GET was created as a source of a "second opinion"; it fills a critical void in the provision of health care for the older adults in our community. Treatment requires an interdisciplinary approach with specialists in geriatrics, gerontology, nutrition, psychology, psychiatry, nursing, social work, physical therapy and other areas integrating their efforts to improve the quality of life for the patient and their family.

## **How does the GET program work?**

A patient is usually referred to GET by his/her physician or a family member. Self-referral can also initiate the process. An information packet is sent to patients who meet the criteria for participation. Included are questionnaires to determine the patient's medical history and nutritional status, and release-of-medical-information forms for attending physicians and hospitals.

When all the information has been received and reviewed by the geriatric team, the patient is scheduled for a comprehensive evaluation. This includes complete history and physical examination, a mental/psychological evaluation, diagnostic tests and an assessment of the patient's functional abilities. The team then determines the patient's needs for medication or other therapeutic measures.

On rare occasions, a home visit may be scheduled to determine the patient's ability to function within the home, the quality of his/her interpersonal relations with family and friends, and his/her mental health. The home is evaluated for potential health and safety hazards. Based on the team's findings, the patient may be assisted in utilizing appropriate community resources.

The patient and his/her family members are informed of the results of the diagnostic tests and examinations, and the recommendations of the medical team. A written report of the consultation is provided to the patient and his/her attending physician for ongoing care. Physician services are covered by Medicare and other insurance providers. Charges vary depending upon services and procedures required.

## **Who is eligible to participate in the GET program?**

Participation in the GET program is generally most helpful to patients aged 62 and over who have developed potentially reversible dementia and/or diseases amenable to rehabilitation. In order to provide a supportive environment, the participation of relatives, friends, nurses and/or social workers is required. At least one of these must accompany each patient through the evaluation process.

Participation does not require hospitalization, however, hospitalization may be recommended based upon results of the testing and evaluation process. Patients who suffer from advanced stages of serious illnesses may not benefit from this program; however, they are appropriate to be seen by the University of Louisville Physicians Geriatric Medicine Team.

**Services Performed by the GET Program may include:**

- Complete medical history
- Analysis of past medical records
- Physical examination
- Evaluation of medications and their use
- Nutritional assessment
- Psychological evaluations, including memory, emotional, social and behavioral areas
- Laboratory testing
- Caregiver/family interview
- Patient and family counseling and education
- Resource recommendations
- Consultations with other specialists when indicated
- Follow-up evaluations to monitor patient's progress
- Others as needed

**The GET Team members include:**

Faculty Geriatrician (MD)

Geriatric Fellow (MD)

Faculty Doctor of Pharmacy (PharmD)

Social Worker (MSSW, CSW)

Faculty Psychologist (PhD)

## Welcome to the Geriatric Evaluation Treatment Program:

Our comprehensive evaluation takes place in the following three steps:

1. Completion of information forms
2. Scheduling of appointment
3. Office visit(s) – initial and follow up

### Step 1: Gathering Information

Please complete the following forms and return them to us. We cannot schedule an appointment until we receive and review all of them.

1. **Geriatric questionnaire:** To be completed by the patient, family member or caregiver
2. **Authorization to release medical information form:** sign this form and send a copy to all physicians and hospitals used within the past ten years. They will send the records back to you.
3. **Once you have completed 1 and 2, send the packet back to us. We will then contact you to schedule an appointment.**

### Step 2: Scheduling the Evaluation

After we receive the above material, we will call to schedule an appointment. At least one family member or caregiver must accompany the person being evaluated. Parking is available across the street from the Health Care Outpatient Center, at the Health Care Outpatient Care Center Parking Garage (414 Chestnut Street.)

### Step 3: Office Visits

**Please bring with you:**

- Medicare and/or other insurance cards
- All prescription and non-prescription medications, even those not taken on a regular basis
- Eyeglasses, if needed
- Hearing aid(s), if needed

### Evaluation Process:

1. The geriatrician will discuss the presenting problem, review your records, discuss your medical history and perform a physical examination.
2. The gerontologist will perform a memory evaluation and discuss caregiver issues.
3. The geriatrician may schedule laboratory and other tests.
4. Depending on the results of the evaluation, the patient may need to return for a follow-up visit.

## Geriatric Evaluation and Treatment Unit

### BASELINE ASSESSMENT INFORMATION PATIENT/CAREGIVER SECTION

Patient Name \_\_\_\_\_

Age / Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Marital Status:  Married  Single  Widowed  Divorced

Place of birth \_\_\_\_\_

Living Situation:

In own home, alone

In housing for elderly

With spouse

Own a gun

With caregiver

Keep gun loaded

Assisted living facility

Education \_\_\_\_\_

Primary occupation(s) \_\_\_\_\_

Reason for retirement and age at retirement (if retired) \_\_\_\_\_

Interests / hobbies \_\_\_\_\_

Religion \_\_\_\_\_

Military Service:  Yes  No If yes, branch: \_\_\_\_\_

Do you have a Living Will?  Yes  No

Do you have a Durable Power of Attorney?  No

Yes, name \_\_\_\_\_

Do you have a prescription drug plan?  Yes  No

What problem(s) do you want to have evaluated?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What do you want to accomplish by the end of the evaluation?

\_\_\_\_\_  
\_\_\_\_\_

Who is your primary care physician?

\_\_\_\_\_  
\_\_\_\_\_

What has your physician said to you about your problem?

\_\_\_\_\_  
\_\_\_\_\_

Is your physician aware of your request for evaluation at this office?       Yes       No

Primary Caregiver's name(s):

\_\_\_\_\_

Relation to patient \_\_\_\_\_

How long have you been providing care? \_\_\_\_\_

What do you, as caregiver, want to accomplish by the end of this evaluation?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

On a scale of 1 to 5 (with 5 being the most intense), how much burden are you feeling regarding your caregiving?

1      2      3      4      5

How did you hear of the UofL Geriatric Evaluation and Treatment Unit?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Significant Life Events

What do you consider to be the most important or memorable events in your life? Please list everything that has affected your life whether it is good or bad. Make sure to include important dates: births, deaths, marriages, divorces, relocations, disabling illnesses, significant accomplishments, times of severe stress, etc.

Birth to 12

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Age 13 – 21

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Age 22 – 45

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Age 46 – 65

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Age 66 – 75

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Age 75 – present

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### General History

Date of last visit to the doctor: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of last pap smear: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of last mammogram: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of last rectal/prostate exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of last tetanus shot: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of last flu shot: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of last pneumonia shot: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of last TB skin test: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Are you sexually active?  Yes  No

### Health Habits (check all that apply)

Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_ and how often? \_\_\_\_\_

Do you use tobacco?  Yes  No If yes, how much? \_\_\_\_\_ and how often? \_\_\_\_\_

Do you drink coffee?  Yes  No If yes, how much? \_\_\_\_\_ and how often? \_\_\_\_\_

Do you exercise?  Yes  No If yes, how often? \_\_\_\_\_ and how long? \_\_\_\_\_

### OB/GYN History

Number of pregnancies \_\_\_\_\_

Number of miscarriages \_\_\_\_\_

Age menstrual cycle began \_\_\_\_\_

Age menstrual cycle ended \_\_\_\_\_

Have you had a hysterectomy?  Yes  No If yes, what year? \_\_\_\_\_

Were your ovaries removed?  Yes  No

Have you ever taken hormones?  Yes  No

### Functions

Have you ever had trouble with any of the following? (check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Eating              | <input type="checkbox"/> Control of your bladder |
| <input type="checkbox"/> Cooking             | <input type="checkbox"/> Shopping                |
| <input type="checkbox"/> Moving/walking      | <input type="checkbox"/> Driving                 |
| <input type="checkbox"/> Toileting           | <input type="checkbox"/> Managing money          |
| <input type="checkbox"/> Dressing            | <input type="checkbox"/> Taking medications      |
| <input type="checkbox"/> Bathing             | <input type="checkbox"/> Housekeeping            |
| <input type="checkbox"/> Using the telephone |  |

**Family History**

	ALIVE	DECEASED	Age at Death	Major health Problems/Cause of Death
<b>Father</b>				
<b>Mother</b>				
<b>Brothers</b>				
<b>Sisters</b>				
<b>Sons</b>				
<b>Daughters</b>				

Is there a family history of dementia?  No  Yes

If yes, who? \_\_\_\_\_

## Activities of Daily Living Scale (IADL)

M.P. Lawton – E.M. Brody

### A. Ability to use Telephone

1. Operates telephone on own initiative - ... 1  
looks up and dials numbers, etc.
2. Dials a few well-known numbers.... 1
3. Answers telephone but does not dial... 1
4. Does not use telephone at all... 0

### B. Shopping

1. Takes care of all shopping needs ... 1  
independently
2. Shops independently for small purchases... 0
3. Needs to be accompanied on any ... 0  
shopping trip
4. Completely unable to shop... 0

### C. Food Preparation

1. Plans, prepares and serves adequate ... 1  
Meals independently
2. Prepares adequate meals if supplied... 0  
with ingredients
3. Heats, serves and prepares meals, ... 0  
or prepares meals but does not maintain  
adequate diet.
4. Needs to have meals prepared and served...0

### D. Housekeeping

1. Maintains house alone or with occasional... 0  
assistance (eg., "heavy work domestic help".)
2. Performs light daily tasks such as ... 1  
dishwashing, bedmaking.
3. Performs light daily tasks but cannot... 1  
maintain acceptable level of cleanliness.
4. Needs help with all home maintenance... 1  
tasks.

5. Does not participate in any housekeeping... 0  
tasks.

### E. Laundry

1. Does personal laundry completely ... 1
2. Launders small items, rinses stockings etc... 1
3. All laundry must be done by others ... 0

### F. Mode of Transportation

1. Travels independently on public transport-... 1  
ation or drives own car.
2. Arranges own travel via taxi, but does not... 1  
otherwise use public transportation.
3. Travels on public transportation when ... 1  
accompanied by another.
4. Travel limited to taxi or automobile with ... 0  
with assistance of another.
5. Does not travel at all ... 0

### G. Responsibility for own Medications

1. Is responsible for taking medication ... 1  
in correct dosages at correct time.
2. Takes responsibility if medication is ... 0  
prepared in advance in separate dosage.
3. Is not capable of dispensing own ... 0  
medication.

### H. Ability to Handle Finances

1. Manages financial matters independently... 1  
(budgets, writes checks, pays rent, bills, goes  
to bank), collects and keeps track of income.
2. Manages day-to-day purchases, but needs...1  
Help with banking, major purchases, etc.
3. Incapable of handling money ... 0

## Physical Self-Maintenance Scale

### A. Toilet

1. Cares for self at toilet completely, ... no incontinence. 1
2. Needs to be reminded, or needs help in ... cleaning self, or has rare (weekly at most) accidents. 0
3. Soiling or wetting while asleep more ... than once a week. 0
4. Soiling or wetting while awake more ... than once a week. 0
5. No control of bowels or bladder... 0

### B. Feeding

1. Eats without assistance.... 1
2. Eats with minor assistance at meal- ... times and/or with special preparation of food or help in cleaning up after meals. 0
3. Feeds self with moderate assistance ... and is untidy. 0
4. Requires extensive assistance for all ... meals. 0
5. Does not feed self at all and resists ... efforts of others to feed him. 0

### C. Dressing

1. Dresses, undresses and selects ... clothes from own wardrobe. 1
2. Dresses and undresses self, with minor ... assistance. 0
3. Needs moderate assistance in dressing ... or selection of clothes. 0
4. Needs major assistance in dressing ... but cooperates with efforts of others to help. 0
5. Completely unable to dress self and ... resists efforts of others to help. 0

### D. Grooming

*(Neatness, hair, nails, hands, face, clothing)*

1. Always neatly dressed, well groomed, ... without assistance. 1
2. Grooms self adequately with occasional ... minor assistance, e.g., shaving. 0
3. Needs moderate and regular assistance ... or supervision in grooming. 0
4. Needs total grooming care, but can ... remain well-groomed after help from others. 0
5. Actively negates all efforts of others ... to maintain grooming. 0

### E. Physical Ambulation

1. Goes about grounds or city ... 1
2. Ambulates within residence or about ... one block distance. 0
3. Ambulates with assistance of ... *(check one)* 0  
 cane  walker  wheel chair  
 1 \_\_\_\_ Gets in and out without help  
 2 \_\_\_\_ Needs help getting in and out
4. Sits unsupported in chair or wheelchair ... but cannot propel self without help. 0
5. Bedridden more than half the time.... 0

### F. Bathing

1. Bathes self (tub, shower, sponge bath) ... without help. 1
2. Bathes self with help in getting in and ... out of tub. 0
3. Washes face and hands only, but cannot... bathe rest of body. 0
4. Does not wash self but is cooperative... with those who bathe him. 0
5. Does not wash self and resists efforts ... to keep him clean. 0

## Neuropsychiatric Inventory Questionnaire

Patient \_\_\_\_\_ Date \_\_\_\_\_

Informant:  Spouse       Child       Other \_\_\_\_\_

Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems. Circle "yes" only if the symptom has been present in the past month. Otherwise, circle "no". For each item marked "yes": Rate the severity of the symptom (how it affects the patient):

- 1 = Mild (noticeable, but not significant)
- 2 = Moderate (significant, but not a dramatic change)
- 3 = Severe (very prominent; a dramatic change)

Rate the distress you experience because of that symptom (how it affects you):

- 0 = Not distressing at all
- 1 = Minimal (slightly distressing, not a problem to cope with)
- 2 = Mild (not very distressing, generally easy to cope with)
- 3 = Moderate (fairly distressing, not always easy to cope with)
- 4 = Severe (very distressing, difficult to cope with)
- 5 = Extreme/very severe (extremely distressing, unable to cope with)

- |  |  |
|--|--|
| <b>Delusions</b> .....                                   | Does the patient believe that others are stealing from him or her, or planning to harm him or her in some way?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Severity:</b> 1   2   3 <b>Distress:</b> 1   2   3   4   5  |
| <b>Hallucinations</b> .....                              | Does the patient act as if he or she hears voices? Does he or she talk to people who are not there?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Severity:</b> 1   2   3 <b>Distress:</b> 1   2   3   4   5  |
| <b>Agitation / Aggression</b> ....                       | Is the patient stubborn and resistive to help?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Severity:</b> 1   2   3 <b>Distress:</b> 1   2   3   4   5  |
| <b>Depression / Dysphoria</b> ....                       | Does the patient act as if he or she is sad or in low spirits? Does he or she cry?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Severity:</b> 1   2   3 <b>Distress:</b> 1   2   3   4   5  |
| <b>Anxiety</b> .....                                     | Does the patient become upset when separated from you? Does he or she have any other signs of nervousness, such as shortness of breath, sighing, being unable to relax or feeling excessively tense? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Severity:</b> 1   2   3 <b>Distress:</b> 1   2   3   4   5  |
| <b>Elation or Euphoria</b> .....                         | Does the patient appear to feel too good or act excessively happy?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Severity:</b> 1   2   3 <b>Distress:</b> 1   2   3   4   5  |
| <b>Apathy or Indifference</b> ...                        | Does the patient seem less interested in his or her usual activities and in the activities and plans of others?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Severity:</b> 1   2   3 <b>Distress:</b> 1   2   3   4   5  |

### Neuropsychiatric Inventory Questionnaire *(continued)*

<b>Disinhibition</b> .....	Does the patient seem to act impulsively? For example, does the patient talk to strangers as if he or she knows them, or does the patient say things that may hurt people's feelings?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Severity:</b> 1   2   3	<b>Distress:</b> 1   2   3   4   5
<b>Irritability or Lability</b> ....	Is the patient impatient or cranky? Does he or she have difficulty coping with delays or waiting for planned activities?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Severity:</b> 1   2   3	<b>Distress:</b> 1   2   3   4   5
<b>Motor Disturbance</b> .....	Does the patient engage in repetitive activities, such as pacing around the house, handling buttons, wrapping string or doing other things repeatedly?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Severity:</b> 1   2   3	<b>Distress:</b> 1   2   3   4   5
<b>Nighttime Behaviors</b> ....	Does the patient awaken you during the night, rise too early in the morning or take excessive naps during the day?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Severity:</b> 1   2   3	<b>Distress:</b> 1   2   3   4   5
<b>Appetite and Eating</b> ....	Has the patient lost or gained weight, or had a change in the food he or she likes?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Severity:</b> 1   2   3	<b>Distress:</b> 1   2   3   4   5

Figure 3. Neuropsychiatric Inventory Questionnaire. This tool provides a reliable assessment of behaviors commonly observed in patients with dementia.



**Adult Social Assessment** (continued)

9. Do you have trouble walking or getting around?  Yes  No

10. Any current jobs? \_\_\_\_\_ How long? \_\_\_\_\_

11. Number of people living in your home. \_\_\_\_\_ Adults \_\_\_\_\_ Children

Comments \_\_\_\_\_

\_\_\_\_\_

Would you like some information or a referral to a social worker/agency regarding any of the concerns identified above?  Yes  No

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

Patient unable to write

Signature of Staff Member \_\_\_\_\_

\_\_\_\_\_  
Date

Reviewed by \_\_\_\_\_  
Staff Provider

Comments / Action \_\_\_\_\_

\_\_\_\_\_

## Nutrition Screening Form

Today's date: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. BMI \_\_\_\_\_ Frame size: Small Medium Large

What do you consider your best weight? \_\_\_\_\_ (Your adult highest weight \_\_\_\_\_ lowest weight \_\_\_\_\_)

What did you weigh a year ago? \_\_\_\_\_ \* Weight gain/loss in past year - \_\_\_\_\_ + \_\_\_\_\_

How often do you skip meals? (Go longer than 6 hour between meals?)  3 - 4 times/week  1 time/week  rarely

What are your usual eating times? Breakfast \_\_\_\_\_ am/pm, Lunch \_\_\_\_\_ am/pm, Dinner \_\_\_\_\_ pm, Snacks? \_\_\_\_\_

1. How many times a week do you eat fast food meals or snacks?  
 4 times or more  1 to 3 times  rarely
2. How many servings of fruits or vegetables do you eat each day?  
 2 servings or less  3 to 4 servings  5 servings or more
3. How many regular (not diet) soft drinks, or glasses of Kool-Aid, punch, fruit drinks, or sweet tea do you drink each day?  
 3 servings or more  1 to 2 servings  rarely
4. How many times a week do you eat chicken, fish, or beans (like pinto or black beans)?  
 rarely  1 to 2 times  3 times or more
5. How many times a week do you eat snack chips or crackers?  
 4 times or more  2 to 3 times  1 time or less
6. How many times a week do you eat desserts and other sweets?  
 5 times or more  3 to 4 times  2 times or less
7. How much margarine or meat fat do you use to add flavor to vegetables, potatoes, bread, or corn?  
 a fair amount  some  not much

Do you take multiple vitamin / mineral supplements? Yes \_\_\_ No \_\_\_ If yes, what brand? \_\_\_\_\_

\_\_\_\_\_

Do you take herbal supplements? Yes \_\_\_ No \_\_\_ If yes, what kind? \_\_\_\_\_

\_\_\_\_\_

## Nutrition Screening Form *(continued)*

EATING RECORD – Date: \_\_\_\_\_

Please write down everything you ate and drank yesterday in the boxes below:					
6 am – 6 pm			6 pm – 6 am		
Time	Food	Amount	Time	Food	Amount

## Caregiver's Assessment for Physicians of the Elderly (CAPE)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Caregiver Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Quality care for older adults is best provided when there is a working *partnership* between the patient's physician and the caregiver. As caregiver, you are the best observer of changes in the patient which the physician needs to know about – especially, any **gradual or sudden changes** in the person's normal abilities, behavior, memory or mood.

Please help me gather more information about the patient by answering the following questions:

What was the **first change** (from the person's "usual self") you noticed in any of these areas?

- 1) Memory, 2) behavior, 3) mood or emotional state, 4) ability to function independently, 5) ability to care for him/herself and her living environment, and/or 6) ability to work or engage in hobbies and interests.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**When** did this occur? \_\_\_\_\_

Here is a list of problems you may have noticed. For each problem the person has, please indicate, in years or months, approximately how long it has been occurring. Include additional comments you would like to make.

### Self-Care Activities

<b>Does he/she have any difficulties with:</b>	<b>About how long?</b>	
	<b>Years</b>	<b>Months</b>
Control of bowel and/or bladder.....	_____	_____
Using the toilet alone .....	_____	_____
Dressing .....	_____	_____
Eating.....	_____	_____
Walking around the house without help.....	_____	_____
Walking any distance outside of home.....	_____	_____
Grooming.....	_____	_____
Using telephone to call others.....	_____	_____
Doing housecleaning chores.....	_____	_____
Doing laundry.....	_____	_____
Shopping for food and routine items.....	_____	_____
Preparing meals/using stove.....	_____	_____
Taking medicine correctly.....	_____	_____

**Self-Care Activities (continued)**

<b>Does he/she have any difficulties with:</b>	<b>About how long?</b>	
	<b>Years</b>	<b>Months</b>
Driving (if not driving, when did he/she stop?) .....	_____	_____
Paying bills and handling finances.....	_____	_____
Spending money appropriately.....	_____	_____
Getting out of the house and socializing.....	_____	_____
Using some form of transportation to get to a desired location.....	_____	_____
Performing usual hobbies, work and/or volunteer activities.....	_____	_____
Keeping the house and/or yard reasonably clean.....	_____	_____
Keeping the house and yard free from clutter.....	_____	_____
Self-neglect of any kind.....	_____	_____
<i>Are these symptoms gradually getting worse?</i> _____		

**Memory/Thinking/Reasoning Abilities**

<b>Are there any problems remembering:</b>	<b>Years</b>	<b>Months</b>
Things he/she has been told in the previous 5 – 10 minutes.....	_____	_____
Events of the past week or month.....	_____	_____
Events long past (more than one year).....	_____	_____
Names of friends.....	_____	_____
Names of close family members.....	_____	_____
Words he/she wants to say.....	_____	_____
The current season, year, month or day of the week.....	_____	_____
Appointments or scheduled events.....	_____	_____
How to do things he/she used to know how to do, such as how to use a sewing machine or drive a car.....	_____	_____
Where he/she lives.....	_____	_____
Where he/she is in his/her own house.....	_____	_____
Personal events (things that have happened during his/her lifetime, especially long ago)	_____	_____
Where he/she puts things.....	_____	_____
What he/she is doing or talking about (repeats self).....	_____	_____
To secure home/car when vacated, to turn off stove, etc.....	_____	_____
Making reasonable, sound decisions.....	_____	_____
Understanding what he/she is told.....	_____	_____
Understanding what he/she has read.....	_____	_____
Concentrating or paying attention well.....	_____	_____
Having a conversation with you.....	_____	_____
Following the “story line” while watching TV.....	_____	_____
<i>Are these symptoms gradually getting worse?</i> _____		

## Behavior

<i>Does the person have any of these difficulties?</i>	Years	Months
Has trouble getting started on activities.....	_____	_____
Has withdrawn from one or more usual and enjoyed activities.....	_____	_____
Has become lost in a familiar area.....	_____	_____
Wanders aimlessly, especially at night.....	_____	_____
Becomes restless or agitated, especially in the evening.....	_____	_____
Strikes out at you or others or becomes combative.....	_____	_____
Dresses inappropriately.....	_____	_____
Uses too much alcohol.....	_____	_____
Has greater than usual difficulty getting along with friends, relatives or others.....	_____	_____
Takes medicines inappropriately – too much/little, buys own remedies or trades with others.....	_____	_____
Accuses others of stealing or doing something “bad” to him/her.....	_____	_____
Spends long hours in bed.....	_____	_____
Bathes too infrequently.....	_____	_____
Sleeps frequently during the day.....	_____	_____
Has interrupted sleep pattern.....	_____	_____
Awakens early and cannot get back to sleep.....	_____	_____
Has shown a change in handwriting.....	_____	_____
Refuses to eat nutritious food/meals.....	_____	_____
Engages in reckless or dangerous behavior.....	_____	_____
Hoards objects/animals, papers, etc.....	_____	_____
Does <i>anything</i> not consistent with typical behavior – what? .....	_____	_____
<i>Are these symptoms gradually getting worse?</i> _____		

## Mood

<i>Does the person show:</i>	Years	Months
Suspiciousness/mistrust of others.....	_____	_____
Unusual lack of concern about herself/himself or others, and/or events.....	_____	_____
Loss of interest in usual concerns, activities.....	_____	_____
Worry, anxiety or nervousness.....	_____	_____
Anger.....	_____	_____
Hallucinations – seeing, hearing, feeling or smelling things that are not there.....	_____	_____
Frequent and sudden mood changes.....	_____	_____
Inappropriate laughing or crying.....	_____	_____
Sadness.....	_____	_____
States he/she wishes he/she were dead or talks about suicide.....	_____	_____
Preoccupation with self.....	_____	_____
<i>Are these symptoms gradually getting worse?</i> _____		



## Describe how the person spends a typical day:

1. What is his/her rising time? \_\_\_\_\_
2. What does he/she do during each of the following times?
  - a. Morning hours: \_\_\_\_\_  
\_\_\_\_\_
  - b. Afternoon hours: \_\_\_\_\_  
\_\_\_\_\_
  - c. Evening hours: \_\_\_\_\_  
\_\_\_\_\_
3. What is his/her usual bed time? \_\_\_\_\_

## Other

Has the patient been taking medications from physicians other than myself?

Yes  No      If yes, please list below:

\_\_\_\_\_  
\_\_\_\_\_

Please list any over-the-counter or borrowed medicines that the patient is taking:

\_\_\_\_\_  
\_\_\_\_\_

Does the person have access to firearms?       Yes  No

Is there a gun in the house?       Yes  No

How **SAFE** do you think the patient is in his/her current living situation?

\_\_\_\_\_  
\_\_\_\_\_

## Caregiver Wellbeing

*I am interested in your health and well-being also!*

How has caregiving affected the quality of your life?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What else can I or my staff do to assist you in your care of this person?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



### Caregiver Wellbeing (continued)

Do you need additional help caring for the patient?

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Do you need information about community resources (adult day care, support groups, nursing homes, etc.?)

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Additional comments:

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### Caretaker Resource and Burden

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. Where do you care for the patient?          | Own                      | Rent                     |
| <input type="checkbox"/> Patient's home        | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Caretaker's home      | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other (specify) _____ | <input type="checkbox"/> | <input type="checkbox"/> |

2. Number of people living in household, ages and relationship

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3. What is your current status and other regular activities outside the home?

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4. How have these activities changed as a result of caring for this patient?

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- |   |                          |                          |
|---|--------------------------|--------------------------|
| 5. Which patient behaviors are difficult to manage? | Yes                      | No                       |
| <input type="checkbox"/> Abusive behavior           | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Wandering                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Incontinence               | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sleeplessness              | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other (specify) _____      | <input type="checkbox"/> | <input type="checkbox"/> |

6. How much time per week do you spend on patient care? \_\_\_\_\_

7. Specify regular assistance you receive in caregiving and/or financial support:

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8. Specify types of care the patient requires:

\_\_\_\_\_

\_\_\_\_\_

9. How much does this care cost you? \_\_\_\_\_

10. Do you currently use:

Yes No

Adult day care

In-home respite care

Chore service

Inpatient respite care

Other in-home services \_\_\_\_\_

11. When and how long was your most recent vacation or sustained period of respite? \_\_\_\_\_

\_\_\_\_\_

12. What future plans do you foresee for the patient?

\_\_\_\_\_

\_\_\_\_\_

13. How do you feel about institutional care for the patient if the need arises?

\_\_\_\_\_

\_\_\_\_\_

14. Do you feel that you have adequate finances and services to care for this patient? If not, what would help?

\_\_\_\_\_

\_\_\_\_\_

15. What is the status of your health?

\_\_\_\_\_

\_\_\_\_\_

Please check the appropriate box, based on the patient's feelings and behavior during the past two weeks:

Yes	No	Question
		1. Does the patient feel a deep sense of depression, sadness or hopelessness most of the day?
		2. Have they experienced diminished interest in most activities?
		3. Have they experienced significant appetite or weight changes when not dieting?
		4. Have they experienced a significant change in sleeping patterns?
		5. Do they feel unusually restless or sluggish?
		6. Do they feel unduly fatigued?
		7. Do they experience persistent feelings of hopelessness or inappropriate feelings of guilt?
		8. Have they experienced a diminished ability to think or concentrate?
		9. Do they have recurrent thoughts of death or suicide?

