My Family Medical Group
FALLS RISK ASSESSMENT

☐ Admission _____ ☐ Annual ☐ Post-Fall

Circle appropriate score for each section and total score at bottom.

	Parameter	Score	Patient Status/Condition
A.	Level of Consciousness/ Mental Status	0	Alert and oriented X 3
		2	Disoriented X 3
		4	Intermittent confusion
B.	History of Falls (past 3 months)	0	No falls
		2	1-2 falls
		4	3 or more falls
C.	Ambulation/ Elimination Status	0	Ambulatory & continent
		2	Chair bound & requires assistance with toileting
		4	Ambulatory & incontinent
D.	Vision Status	0	Adequate (with or without glasses)
		2	Poor (with or without glasses)
		4	Legally blind
E.	Gait and Balance		Have patient stand on both feet w/o any type of assist then have walk: forward, thru a doorway, then make a turn. (Mark all that apply.)
		0	Normal/safe gait and balance.
		1	Balance problem while standing,
		1	Balance problem while walking.
		1	Decreased muscular coordination.
		1	Change in gait pattern when walking through doorway.
		1	Jerking or unstable when making turns.
		1	Requires assistance (person, furniture/walls or device).
F.	Orthostatic Changes	0	No noted drop in blood pressure between lying and standing. No change to cardiac rhythm.
		2	Drop<20mmHg in BP between lying and standing. Increase of cardiac rhythm <20.
		4	Drop >20mmHg in BP between lying and standing. Increase of cardiac rhythm>20.
G.	Medications		Based upon the following types of medications: anesthetics, antihistamines, cathartics, diuretics, antihypertensive, antiseizure, benzodiazepines, hypoglycemic, psychotropic, sedative/hypnotics.
		0	None of these medications taken currently or w/in past 7 days.
		2	Takes 1-2 of these medications currently or w/in past 7 days.
		4	Takes 3-4 of these medications currently or w/in past 7 days.
		1	Mark additional point if patient has had a change in these medications or doses in past 5 days.
H.	Predisposing Diseases		Based upon the following conditions: hypertension, vertigo, CVA, Parkinsons Disease, loss of limb(s), seizures, arthritis, osteoporosis, fractures.
		0	None present
		2	1-2 present
		4	3 or more present
I.	Equipment Issues	0	No risk factors noted
		1	Oxygen tubing
		1	Inappropriate or client does not consistently use assistive device.
		1	Equipment needs:
		1	Other:
TOTAL SCORE			**Score of 8 to 14 = Moderate risk for falls** **Score of 15 or Above = High risk for falls**

Patient has been informed about fall risk assessment results and/or safety/fall prevention recommendations:

☐ Yes ☐ No

Nurse's Signature	Date *(Month, day, year)*	Time

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Patient Name:_____ **DOB:**_____

Date:_____ **PATIENT ID#:** _____

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	**Independence** (1 Point) **NO** supervision, direction or personal assistance.	**Dependence** (0 Points) **WITH** supervision, direction, personal assistance or total care.
BATHING Points:	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points:	**(1 POINT)** Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING Points:	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points:	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points:	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder
FEEDING Points:	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS: _____ **SCORING:** 6 = High (*patient independent*) 0 = Low (*patient very dependent*

Mini Nutritional Assessment
MNA®

Nestlé Nutrition Institute

Last name: First name:

Sex: Age: Weight, kg: Height, cm: Date:

Complete the screen by filling in the boxes with the appropriate numbers.
Add the numbers for the screen. If score is 11 or less, continue with the assessment to gain a Malnutrition Indicator Score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake

B Weight loss during the last 3 months
0 = weight loss greater than 3kg (6.6lbs)
1 = does not know
2 = weight loss between 1 and 3kg (2.2 and 6.6 lbs)
3 = no weight loss

C Mobility
0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out

D Has suffered psychological stress or acute disease in the past 3 months?
0 = yes 2 = no

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems

F Body Mass Index (BMI) = weight in kg / (height in m)²
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater

Screening score (subtotal max. 14 points)
12-14 points: Normal nutritional status
8-11 points: At risk of malnutrition
0-7 points: Malnourished
For a more in-depth assessment, continue with questions G-R

Assessment

G Lives independently (not in nursing home or hospital)
1 = yes 0 = no

H Takes more than 3 prescription drugs per day
0 = yes 1 = no

I Pressure sores or skin ulcers
0 = yes 1 = no

J How many full meals does the patient eat daily?
0 = 1 meal
1 = 2 meals
2 = 3 meals

K Selected consumption markers for protein intake
- At least one serving of dairy products (milk, cheese, yoghurt) per day — yes / no
- Two or more servings of legumes or eggs per week — yes / no
- Meat, fish or poultry every day — yes / no

0.0 = if 0 or 1 yes
0.5 = if 2 yes
1.0 = if 3 yes

L Consumes two or more servings of fruit or vegetables per day?
0 = no 1 = yes

M How much fluid (water, juice, coffee, tea, milk...) is consumed per day?
0.0 = less than 3 cups
0.5 = 3 to 5 cups
1.0 = more than 5 cups

N Mode of feeding
0 = unable to eat without assistance
1 = self-fed with some difficulty
2 = self-fed without any problem

O Self view of nutritional status
0 = views self as being malnourished
1 = is uncertain of nutritional state
2 = views self as having no nutritional problem

P In comparison with other people of the same age, how does the patient consider his / her health status?
0.0 = not as good
0.5 = does not know
1.0 = as good
2.0 = better

Q Mid-arm circumference (MAC) in cm
0.0 = MAC less than 21
0.5 = MAC 21 to 22
1.0 = MAC greater than 22

R Calf circumference (CC) in cm
0 = CC less than 31
1 = CC 31 or greater

Assessment (max. 16 points)
Screening score
Total Assessment (max. 30 points)

Malnutrition Indicator Score
24 to 30 points: Normal nutritional status
17 to 23.5 points: At risk of malnutrition
Less than 17 points: Malnourished

References
1. Vellas B, Villars H, Abellan G, *et al.* Overview of the MNA® - Its History and Challenges. *J Nutr Health Aging.* 2006; **10:456**-465.
2. Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF). *J. Geront.* 2001; **56A**: M366-377
3. Guigoz Y. The Mini-Nutritional Assessment (MNA®) Review of the Literature - What does it tell us? *J Nutr Health Aging.* 2006; **10**:466-487.

For more information: www.mna-elderly.com

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Six Item Cognitive Impairment Test (6CIT)

(6CIT - Kingshill Version 2000, Dementia screening tool)

Patient's Name: **Patient's DOB:**	**Date:** **Provider/Nurse:**

Question	Score Range	Score
1. What year is it?	**0 – 4** Correct - 0 points Incorrect – 4 points	
2. What month is it?	**0 – 3** Correct – 0 points Incorrect – 3 points	
3. Give the patient an address phrase to remember with 5 components, eg **John, Smith, 42, High St, Bedford**		
4. About what time is it (within 1 hour)	**0 – 3** Correct – 0 points Incorrect – 3 points	
5. Count backwards from 20-1	**0- 4** Correct - 0 points 1 error – 2 points More than I error – 4 points	
6. Say the months of the year in reverse	**0- 4** Correct - 0 points 1 error – 2 points More than I error – 4 points	
7. Repeat address phrase **John, Smith,** **42, High St,** **Bedford**	**0 – 10** Correct - 0 points 1 error – 2 points 2 errors – 4 points 3 errors – 6 points 4 errors – 8 points All wrong – 10 points	
TOTAL SCORE	**0 – 28**	**/28**

Outcome from Score

0-7 = normal	**Referral not necessary at present**
8- 9 = mild cognitive impairment	**Probably refer**
10-28 = significant cognitive impairment	**Refer**

Comprehensive Pain Assessment Form
Cognitively Intact

Name_____ **ID #**_____ **Room #** _____

Assessment Date _____ **Time** _____ **Health Care Provider** _____

Individual's Pain Control Goal	Individuals Pain Intensity Goal
☐ Sleep comfortably ☐ Comfort at rest ☐ Comfort with movement ☐ Total pain control ☐ Stay alert ☐ Perform desired activities ☐ Other:_____	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Check the correct rating)

Current Pain-related Diagnosis(es): _____

Reason for Assessment: ☐MDS Admission ☐MDS Significant Change ☐MDS Readmission ☐MDS Quarterly ☐ MDS Annual ☐New Condition ☐Routine Monitoring

Type of Pain: ☐ Nociceptive (Joint/bone/soft tissue) ☐ Neuropathic ☐ Mixed

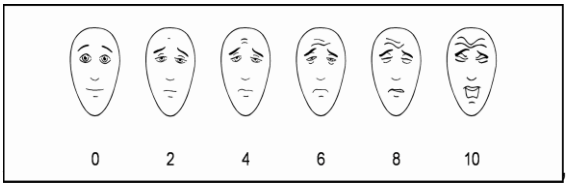
Depression (yes/no): ____ Depression Scale:_____Score:_____Date:_____

Intensity of Pain: Scale Used

☐**Numerical 0-10** (circle the correct rating)

0 1 2 3 4 5 6 7 8 9 10
↑ ↑ ↑
No Pain Moderate Pain Worst Possible Pain

☐**Faces Pain Scale-Revised**



counting left to right with 0= "no pain" and 10 the intensity of your pain now.

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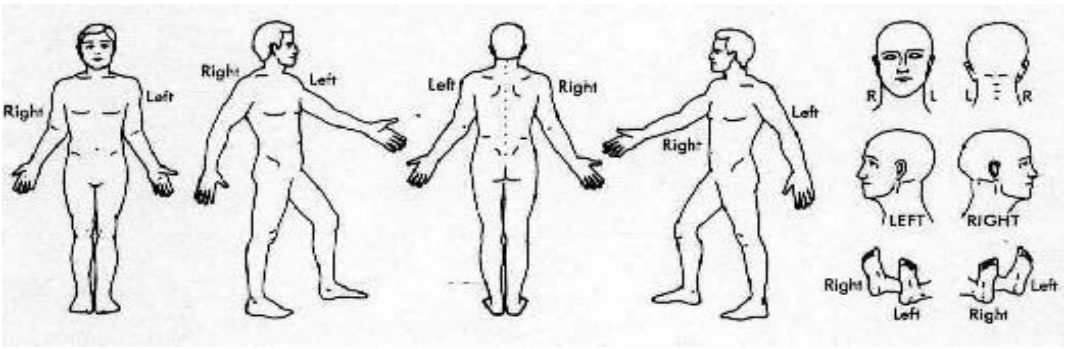
☐**Verbal Descriptor Scale**
Circle the words that best represent "worst pain possible".

No pain Mild pain Moderate pain Severe pain Extreme pain Pain as bad as could be

Location: (Individual or nurse mark drawing) Mark on the areas where you feel pain. If you feel more than one sensation in the same area, mark over that area with all the symbols that apply. Make sure you show all affected areas.

O Aching
/ Burning
 # Cramping
= Crushing
◆ Dull
*** Numbness**
+ Pins/needles
● Sharp
↓ Stabbing
↑ Throbbing



History of Pain

Onset of Pain: ☐New (last 7 days) ☐Recent (last 3 mos.) ☐More distant (> 3 mos.) ☐Unknown

Frequency of Pain: ☐Constant ☐Frequent ☐Infrequent ☐ Unknown

Description of Pain: ☐Aching ☐Burning ☐Cramping ☐Crushing ☐Dull ☐Numbness

☐Pins & Needles ☐Sharp ☐Shooting ☐Throbbing ☐Other: _____

Change in Pattern of Pain: Has the pain changed in description or intensity the last 7 days?

☐ Yes ☐No ☐Unknown If yes, describe the change: _____

Causes/Increases in Pain: ☐Movement ☐Coughing ☐Cold ☐Heat ☐Fatigue ☐Anxiety
☐Other, describe: _____

What Relieves the Pain: ☐Cold ☐Heat ☐Exercise ☐EatingOpioids ☐Non-Opioid Meds
☐Adjuvants ☐Herbals ☐Massage ☐Relaxation ☐Rest ☐Repositioning ☐Distraction
☐Other: _____

Pain Medication History: _____

_____

Effects of Pain: Using the following scale, rate how the pain has had an effect in each area in the past 24 hours: **0** (no effect) **2** (mild effect) **5** (moderate effect) **10** (severe effect)

Accompanying Symptoms (e.g., nausea)____Sleep Disturbance_____Appetite Change _____
Physical Activity Change____ Mood/Behavior____ Concentration____Relationship with Others_____ Other (describe): _____

Worst Pain in 24 Hours: 0 1 2 3 4 5 6 7 8 9 10

↑ No Pain ↑ Moderate Pain ↑ Worst Possible Pain

In the past 24 hours, how much have the medications or treatments eased your pain?

0 No relief **2** Mild relief **5** Moderate relief **8** Relief **10** Complete relief

Plan for Addressing Pain: ☐Initiate pain management flow sheet ☐Call Prescriber Refer
☐to pain team ☐Rehab referral (PT, OT, ST) ☐Non-med intervention
☐Medications prescribed ☐Spiritual counseling ☐Staff education/communication
☐ Other, describe: _____

Comments: _____

_____

_____

Signature of person completing assessment: _____

Title: _____**Date**: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DOB: _____ DATE: _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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Patient's Name: _____ DOB: _____
Date:_____

Urinary Incontinence Assessment in Older Adults

UROGENITAL DISTRESS INVENTORY SHORT FORM (UDI-6)

Please answer each question by checking the best response. While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas, but please fill out this form as completely as possible.

Do you experience, and if so, how much are you bothered by…	Not at all	Somewhat	Moderately	Quite a Bit
1. Frequent urination	0	1	2	3
2. Leakage related to feeling of urgency	0	1	2	3
3. Leakage related to physical activity, coughing, or sneezing	0	1	2	3
4. Small amounts of leakage (drops)	0	1	2	3
5. Difficulty emptying bladder	0	1	2	3
6. Pain or discomfort in lower abdominal or genital area	0	1	2	3

INCONTINENCE IMPACT QUESTIONNAIRE-SHORT FORM (IIQ-7)

Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage.

Has urine leakage affected your…	Not at all	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3
2. Physical recreation such as walking, swimming, or other exercise?	0	1	2	3
3. Entertainment activities (movies, concerts, etc.)?	0	1	2	3
4. Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
5. Participation in social activities outside your home?	0	1	2	3
6. Emotional health (nervousness, depression, etc.)?	0	1	2	3
7. Feeling frustrated?	0	1	2	3

Items 1 and 2 = physical activity; Items 3 and 4 = travel
Item 5 = social/relationships; Items 6 and 7 = emotional health

Scoring: Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

Reference: Uebersax, J.S., Wyman, J.F., Shumaker, S.A., McClish, D.K., Fantl, J.A., & the Continence Program for Women Research Group. (1995). Short forms to assess life quality and symptom distress for urinary incontinence in women: the Incontinence Impact Questionnaire and the Urogenital Distress Inventory. *Neurology and Urodynamics, 14*(2), 131-139.

The Women's Health Center of Excellence for Research, Leadership, Education (WHCoE) administers the distribution and use of these two questionnaires. On request, they will send copies of the self-administered instruments (both short and long forms), and scoring materials for each instrument. Requests may be made at the website: http://www.wakehealth.edu/School/OWIMS/IIQ-and-UDI-Instrument.htm.

try this: general assessment series
Best Practices in Nursing Care to Older Adults

A series provided by The Hartford Institute for Geriatric Nursing, NYU Rory Meyers College of Nursing

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