Department of Family & Geriatric Medicine
UofL Health Care Outpatient Center
401 E. Chestnut Street, Suite 170
Louisville, KY 40202

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.

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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.

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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)

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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.

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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
- ☐ With spouse
- ☐ With caregiver
- ☐ Assisted living facility
- ☐ In housing for elderly
- ☐ Own a gun
- ☐ Keep gun loaded

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

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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?

_____

_____

_____

_____

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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

Age 13 – 21

Age 22 – 45

Age 46 – 65

Age 66 – 75

Age 75 – present

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Medical History

We hope to get to know your medical history in order to serve you better. Please complete this form to the best of your ability. Feel free to add any information that you think would be beneficial in treating you as a patient.

Past Medical History

History of Surgeries	Year

Other Hospitalizations	Year

Blood Transfusions	Year

Present Medications (including over the counter and herbal)

Medicine and Dosage	How Often?	Prescribing Doctor

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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)

☐ Eating
☐ Cooking
☐ Moving/walking
☐ Toileting
☐ Dressing
☐ Bathing
☐ Using the telephone
☐ Control of your bladder
☐ Shopping
☐ Driving
☐ Managing money
☐ Taking medications
☐ Housekeeping

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Family History

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

Is there a family history of dementia? ☐ No ☐ Yes

If yes, who? _____

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Activities of Daily Living Scale (IADL)

M.P. Lawton – E.M. Brody

A. Ability to use Telephone

1. Operates telephone on own initiative - … looks up and dials numbers, etc. 1
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 … independently 1
2. Shops independently for small purchases… 0
3. Needs to be accompanied on any … shopping trip 0
4. Completely unable to shop… 0

C. Food Preparation

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

D. Housekeeping

1. Maintains house alone or with occasional… assistance (eg., “heavy work domestic help”.) 0
2. Performs light daily tasks such as … dishwashing, bedmaking. 1
3. Performs light daily tasks but cannot… maintain acceptable level of cleanliness. 1
4. Needs help with all home maintenance… tasks. 1
5. Does not participate in any housekeeping… tasks. 0

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

G. Responsibility for own Medications

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

H. Ability to Handle Finances

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

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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 … 0
   (check one)
   ☐ 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

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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)

Delusions ……
Does the patient believe that others are stealing from him or her, or planning to harm him or her in some way?
☐ Yes ☐ No **Severity: 1 2 3** **Distress: 1 2 3 4 5**

Hallucinations …….
Does the patient act as if he or she hears voices? Does he or she talk to people who are not there?
☐ Yes ☐ No **Severity: 1 2 3** **Distress: 1 2 3 4 5**

Agitation / Aggression ….
Is the patient stubborn and resistive to help?
☐ Yes ☐ No **Severity: 1 2 3** **Distress: 1 2 3 4 5**

Depression / Dysphoria ….
Does the patient act as if he or she is sad or in low spirits? Does he or she cry?
☐ Yes ☐ No **Severity: 1 2 3** **Distress: 1 2 3 4 5**

Anxiety…….
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?
☐ Yes ☐ No **Severity: 1 2 3** **Distress: 1 2 3 4 5**

Elation or Euphoria…..
Does the patient appear to feel too good or act excessively happy?
☐ Yes ☐ No **Severity: 1 2 3** **Distress: 1 2 3 4 5**

Apathy or Indifference …
Does the patient seem less interested in his or her usual activities and in the activities and plans of others?
☐ Yes ☐ No **Severity: 1 2 3** **Distress: 1 2 3 4 5**

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Neuropsychiatric Inventory Questionnaire *(continued)*

Disinhibition …… 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?

☐ Yes ☐ No **Severity: 1 2 3 Distress: 1 2 3 4 5**

Irritability or Lability …. Is the patient impatient or cranky? Does he or she have difficulty coping with delays or waiting for planned activities?

☐ Yes ☐ No **Severity: 1 2 3 Distress: 1 2 3 4 5**

Motor Disturbance…… Does the patient engage in repetitive activities, such as pacing around the house, handling buttons, wrapping string or doing other things repeatedly?

☐ Yes ☐ No **Severity: 1 2 3 Distress: 1 2 3 4 5**

Nighttime Behaviors…. Does the patient awaken you during the night, rise too early in the morning or take excessive naps during the day?

☐ Yes ☐ No **Severity: 1 2 3 Distress: 1 2 3 4 5**

Appetite and Eating…. Has the patient lost or gained weight, or had a change in the food he or she likes?

☐ Yes ☐ No **Severity: 1 2 3 Distress: 1 2 3 4 5**

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

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Adult Social Assessment

Patient Name _____

Dear Patient or Family Member, we are asking for some information about your family and your living situation in an effort to better serve your needs. This information will be kept confidential unless you authorize us to share it with other agencies. It will become a part of your medical record.

☐ I choose not to complete this form today.

_____
Patient Signature Date

Names of immediate family members	***Relationship*** ***(parent, brothers, sisters, spouse, children)***

Please answer the following questions, skip any you prefer not to answer.

1. Are there problems with your current living conditions? ☐ Yes ☐ No
2. Do people living with you have serious medical or emotional problems? ☐ Yes ☐ No
3. Have you experienced any major family problems in the last year? ☐ Yes ☐ No
4. Do your work and health interfere with each other? ☐ Yes ☐ No
5. Are you having problems with medical bills? ☐ Yes ☐ No
6. Are you having problems paying for medications? ☐ Yes ☐ No
7. Are you having trouble with transportation to your clinic appointments? ☐ Yes ☐ No
8. Do you speak, hear and understand English well? ☐ Yes ☐ No

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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 _____

_____ Reviewed by _____
Date Staff Provider

Comments / Action _____

_____

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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? _____

_____

_____

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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

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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

Does he/she have any difficulties with:	About how long? Years	Months
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	_____	_____

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Self-Care Activities (continued)

Does he/she have any difficulties with:	**About how long? Years**	**Months**
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……..	_____	_____

Are these symptoms gradually getting worse? _____

_____

Memory/Thinking/Reasoning Abilities

Are there any problems remembering:	**Years**	**Months**
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……	_____	_____

Are these symptoms gradually getting worse? _____

_____

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Behavior

Does the person have any of these difficulties?	**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 your 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 *anything* not consistent with typical behavior – what?	_____	_____

Are these symptoms gradually getting worse? _____

_____

Mood

Does the person show:	**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	_____	_____

Are these symptoms gradually getting worse? _____

_____

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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?

_____

_____

_____

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Caregiver Wellbeing (continued)

Do you need additional help caring for the patient?

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

Additional comments:

Caretaker Resource and Burden

1. Where do you care for the patient?

	Own	Rent
☐ Patient's home	☐	☐
☐ Caretaker's home	☐	☐
☐ Other (specify) _____	☐	☐

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

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

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

5. Which patient behaviors are difficult to manage?

	Yes	No
☐ Abusive behavior	☐	☐
☐ Wandering	☐	☐
☐ Incontinence	☐	☐
☐ Sleeplessness	☐	☐
☐ Other (specify)	☐	☐

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 is 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?

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